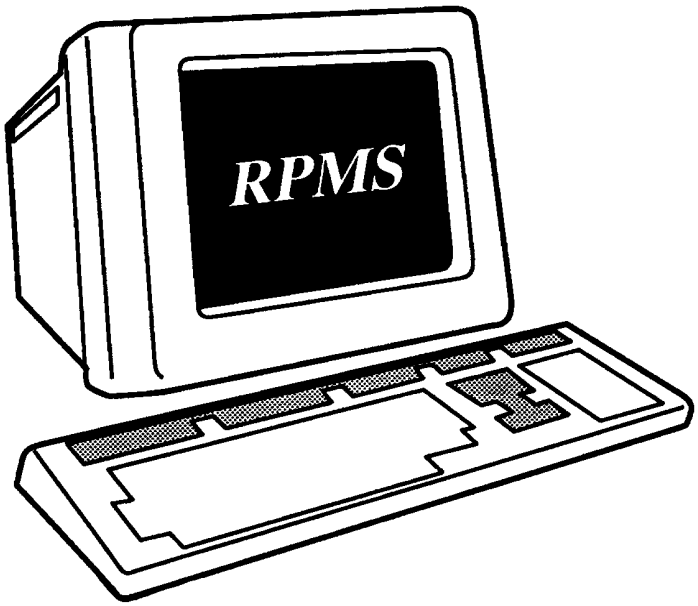


# Women's Health User Manual

**June 1996**
**Version 2.0**

**Indian Health Service**
**Alaska Native Medical Center**
**Computer Information Systems**
**Anchorage, Alaska**

*PREFACE*

*This is the User Manual for the RPMS Women's Health software module. Its purpose is to provide useful information to ordinary users as well as computer personnel regarding the setup, use and operation of the RPMS Women's Health software.*

*Much credit for this User Manual goes to Patrick Foster of Eagle Butte, South Dakota for organizing the ideas of the manual into a coherent form, for writing the first draft of the manual, and for tireless testing of the early versions of the RPMS Women's Health software.*

*Michael Remillard, DDS*
*1 June 1996*

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# Introduction

The Indian Health Service (IHS) Resource and Patient Management System (RPMS) Women's Health Software development effort began in 1993 with a national team of Indian Health Service program people. Using feedback from staff in the field regarding the earlier PAP Tracking software, the team collaborated on new design requirements for software to be used in tracking women receiving PAP Smears and Colposcopies. Over time, the scope of the software broadened to include a full range of breast and cervical cancer screening and tracking functions. Version 1.0 of the software was released in July of 1995. Features of the software include the printing of customizable form letters, the ability to track patients' breast and cervical treatment needs and due dates, and an array of patient management reports and epidemiological reports.

Version 2.0 enhancements of the Women's Health Software include the ability to download procedure results from Corning Clinical laboratories, the ability to export Minimum Data Elements for transmission to the Center for Disease Control, and links to IHS Radiology and the IHS Patient Care Component modules of the RPMS.

This manual is designed to aid healthcare staff in the use of RPMS Women's Health. While there is context-sensitive on-line help available at all prompts (by entering a "?"), this manual will provide a more complete and organized presentation of the features of the software.

# Overview of the Software

## *Main Features*

### Patient Management and Management Reports

The RPMS Women's Health Software functions in two main areas: Patient Management and Management Reports.

**Patient Management** is the portion of the software used to manage individual patients, their procedures, due dates and correspondence. Under the Patient Management menu it is possible to maintain patient data such as the date of the patient's next PAP smear or colposcopy or mammogram, patient's pregnancy and her EDC, as well as the patient's current PAP Regimen. It is also possible to track the patient's individual procedures: the date performed, the provider and clinic, the results or diagnosis, etc. Notifications (letters and phone calls) may also be tracked. This is also the section where CDC-funded sites complete CDC required data such as: Diagnostic Workup, Final Diagnosis of PAP/Colposcopy, Status of Treatment, etc. A file of form letters has been included in the software which allows the letters to be edited and personalized for a clinic's particular needs. Reminder letters can be queued months in advance of an appointment, to be printed and mailed out shortly before the appointment.

**Management Reports** is the portion of the software used to print epidemiological reports, such as the number of women who received a mammogram for the selected time period, or the number of patients having abnormal PAP results during a selected time period. Under Management Reports it is possible to produce lists of patients who are past their due dates for follow-up procedures. It is also possible to store program statistics by date for later comparison of program trends and progress.

### Patients, Procedures, and Notifications

In the RPMS Women's Health Software there are three basic data elements: Patients, Procedures, and Notifications.

**Patients** refer to the women in the program register. Data stored under each patient includes demographic data, the patient's Case Manager, the patient's current or next PAP treatment need and its due date, the patient's PAP regimen and the date it began, the patient's current or next Mammogram treatment need and its due date, and other data. This type of data is referred to as the patient's Case Data.

**Procedures** refer to any of the Procedures tracked by the software. The table of Procedure Types includes PAP smear, colposcopy, mammogram, LEEP, cone biopsy, ECC, and others. The results or diagnosis associated with these procedures are chosen from a table of Bethesda-consistent terminology.

**Notifications** refer to any type of communication or correspondence with the patient, such as first, second and third letters, certified letters, phone calls, messages left, etc. Notifications which take the form of letters fall into two categories: *Results* letters and *Reminder* letters. *Results* letters inform the patient of the results of a recent procedure and are queued to print immediately. *Reminder* letters inform the patient of the need to schedule her next appointment and are queued to print at some time several weeks or months in the future.

The group of reports that look for the due dates of Patients' Treatment Needs, of Procedures, and of Notifications provide a comprehensive mechanism for guarding against losing patients to follow-up.

### Case Managers and the Program Manager

Every patient that is entered into the RPMS Women's Health database (or "register") is assigned a Case Manager. A **Case Manager** is a user of the RPMS Women's Health who is responsible for managing patients. This includes treatment planning, tracking of procedures, editing patient data, selecting appropriate letters, scanning for delinquent needs, and more. A small clinic using RPMS Women's Health may have only one Case Manager. Larger clinics and hospitals may have several.

The **Program Manager** is the person chiefly responsible for the setup and operation of the RPMS Women's Health at a given site. This person works with the computer site manager on the technical aspects of the software and performs maintenance tasks that require a more detailed understanding of the software than is required of Case Managers. At small sites, the Program Manager may also be the only Case Manager. (This individual is assigned the BWZ MANAGER key by the site manager.)

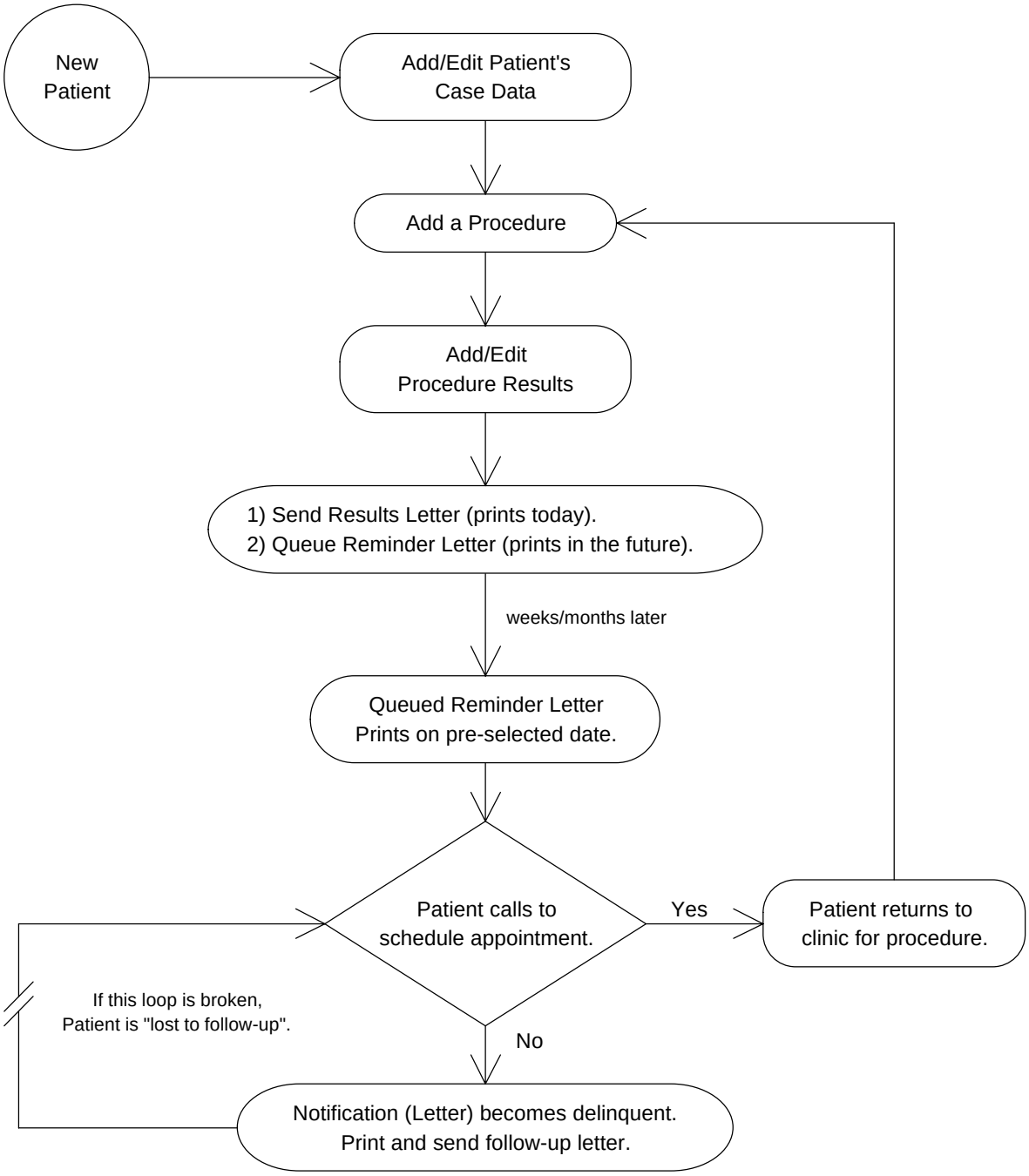
## *The Basic Patient Management Loop*

The function of the RPMS Women's Health Software is best understood in terms of the **Basic Patient Management Loop** (please refer to the flowchart on the following page).
The loop is a sequence of events that occur over and over again during a patient's life.

This software uses the concept of Procedures and Notifications being *open* and *closed*. Procedures and Notifications will become delinquent if they are not *closed* by the "Complete by (Date)" field found in the Notification and Procedure screens. If a Procedure or Notification is not *closed* by its due date, this will be an indicator that the patient may be "lost" to follow-up. Generally, a Procedure is closed when the results or diagnosis for that Procedure are entered; a Notification is closed either at the time it is printed (as in the case of a *results* letter) or when the patient returns for her next appointment (as in the case of a *reminder* letter).

An example of the Basic Patient Management Loop would be the following: A new patient presents to the clinic for care. The patient's Case Data (PAP and MAM treatment needs, EDC, etc.) are entered into the RPMS Women's Health program. Next, some Procedure is performed (such as a PAP smear). The Procedure is entered into the computer, an accession number is assigned to the procedure, and the specimen is sent to a lab for diagnosis. After a period of days, results are returned from a lab and entered for the Procedure and this Procedure is then *closed*. At that time, one and possibly two separate Notification letters are selected from the Purpose of Notification file: the first letter, a *results* letter, informs the patient of the results of the procedure. This letter is printed immediately. The second letter, a *reminder* letter, will advise the patient to call the clinic in order to schedule her next appointment. This second letter is queued to print one year later (assuming the PAP was normal). One year later, in response to the *reminder* letter, the patient calls to schedule her next appointment. When she returns to the clinic for her next Procedure, the Patient Management Loop begins again: procedure... results...*results* letter & *reminder* letter...call for an appointment...procedure. When the patient returns for a Procedure, it is important to *close* the *reminder* letter that prompted her appointment; otherwise, the *reminder* letter will be left *open* and begin to show up as delinquent on the past due reports.

# Basic Patient Management Loop



As noted earlier, the group of reports that look for the due dates of Patients' Treatment Needs, of Procedures, and of Notifications provide a comprehensive mechanism for guarding against losing patients to follow-up. The three sets of "due dates" are as follows:

**1) Treatment Need Due Dates**

Stored as part of each patient's Case Data are Breast Treatment Needs and Cervical Treatment Needs. These needs are chosen from a table and given a due date, such as, "Routine PAP (by 7/1/95)". The RPMS Women's Health software offers a report that will display/print all of the patients with Treatment Needs past due.

**2) Procedure Complete by Dates**

A "Complete by Date" is stored as part of each Procedure a patient receives. When a Procedure is first entered, it receives a status of "OPEN". When the results of the Procedure are returned and entered, the status is generally changed to "CLOSED".

If a Procedure's status remains "OPEN" after its "Complete by Date", the Procedure will begin to display on reports that look for Procedures that are past due.

**3) Notification Complete by Dates**

A "Complete by Date" is stored as part of each Notification a patient receives. When a Notification is first entered, it receives a status of "OPEN". If the Notification is a *Results* letter (to be printed immediately) or a phone call, it is generally given an outcome and a status of "CLOSED". If the Notification is a *Reminder* letter, it's status is left "OPEN" until the patient's next procedure is entered. If a Notification's status remains "OPEN" after its "Complete by Date", the Notification will begin to display on reports that look for Notifications that are past due.

## *Summary*

In summary, the RPMS Women's Health is largely a patient management tool for tracking the breast and cervical treatment needs of women, the procedures they receive, and the communications between healthcare staff and women regarding their treatment and follow-up. The software also provides some program-wide epidemiological reports which may be of use to clinicians and program administrators. This second aspect of the software will be further developed in future versions.

# Conventions in the Software and Manual

### IHS versus VA/State as Type of Agency

If this software is being used at a VA or State site rather than an IHS site, the Type of Agency parameter should be set to VA or State (see page 22). If the Type of Agency is set to VA or State, then anywhere in this manual and on screens and printouts of the software where "Chart#" would normally appear, "Chart#" will instead be replaced by "SSN" and followed by the patient's social security number.

### Double Slash // and the RETURN Key

Frequently, the software will ask you a question, followed by a prompt, followed by two slashes //. The answer displayed in front of the two slashes is the default answer for that question. Pressing the RETURN key will select the default answer (this is so you don't have to type it out). If you do not want to take the default answer (or if no default answer is presented with double slashes), simply type in your response and then press the RETURN key. When you enter a Procedure or Notification screen, the field that you are working with will be highlighted. To get to the next field you would use the RETURN or Arrow (see below) Keys.

### Printscreens (examples of screens you will see)

All examples of what you will see on your screen will be enclosed in a box as shown below:

```
   WOMEN'S HEALTH:          *  MANAGEMENT REPORTS  *          EAGLE BUTTE
                            ========================


  BP     Browse Patients With Needs Past Due
  PS     Procedure Statistics Report
  RS     Retrieve/Print Earlier Snapshots
  SN     Snapshot of the Program Today

 Select Management Reports Option:
```

figure 1

Whenever you see ***boldface/Italic type like this*** in a sample of display screens, it indicates what you would enter, then press the RETURN key to obtain the displayed response. If the display screen sample shows only the two double slashes (//) without any boldface/italic type, simply press the RETURN key without entering anything. Also note that whenever you type in a response, nothing will happen until you press the RETURN key.

On-line Help: use the '?', '??', etc.,If you want to know what other options are available besides the default choice, you can type a question mark (?), and then press RETURN. Doing this will invoke the on-line help, which will give you additional help in what choices are available. The '?' can be entered any time you are not sure of how to answer a particular question or if you want to know more about the menu choices.

**Backspace and Arrow Keys**

Your BACKSPACE key should move the cursor to the left erasing characters as it goes. The UP and Down arrow keys should move you up and down the fields. The Left and Right arrow keys generally are not used. If you are having problems with these keys check with your site manager.

**Tab Key**

In some screens, such as "Add/Edit a Notification Purpose & Letter", you will notice that if you just RETURN down through the fields you skip past certain fields located on the right hand side of the screen. In most cases these are Word Processing fields, marked by a (WP). The software is designed this way to help you avoid the inconvenience of accidentally dropping into the word processing screen. In order to access these fields, position the cursor on the field immediately to the left of the desired WP field and press the TAB key.

**The 'Hat' (^)**

A special character, the "hat" (also known as the caret), is used to STOP or get out of a particular activity. The "hat" is entered by simultaneously pressing the SHIFT key and the "6". Entering the "^" at any prompt will usually take you back to the preceding prompt or menu. The "hat" may also be used to exit from a long list of results scrolling across the screen.

**The "Select DEVICE: " prompt**

Whenever the software is about to display a list or report, it will ask you to
"Select DEVICE: ". In order to send the report or list to a printer, enter a printer name or number. In order to display the report or list on your screen, enter "HOME" (or 0, the number zero). For help in answering the "Select DEVICE: " prompt, please contact your site manager.

**Press RETURN**

At many points in this manual you are instructed to type some letters and "press RETURN". "RETURN" refers to the Return key on a keyboard of the terminal. (On electric typewriters it was the carriage return key.) On some other keyboards, particular on PC keyboards, this key will be marked "Enter". Press RETURN and Press ENTER are synonymous.

Parts of the preceding descriptions were adapted from the Q-Man Volume 1, Mastering the Basics, Version 2 July 1993, manual.

# Quick Start

When using new software for the first time, many people simply want know how to perform the software's most common function immediately, with the intention of browsing the documentation and other screens later. For RPMS Women's Health, the most common function would be to enter a PAP smear and its result and then to view it on the Patient Profile. This section outlines, step by step, the simple process of entering a PAP for a patient and viewing the patient's Profile. Please note: the example assumes that the software has been installed and that at least one Case Manager has been entered under the Setup instructions (beginning on page 17). If this has not been done, please refer to "Add/Edit Case Managers", page 25, to add a Case Manager.

## *Enter a PAP Smear*

1) Get to the Main Menu (with the help of your site manager, if necessary). The Main Menu screen will look like this:

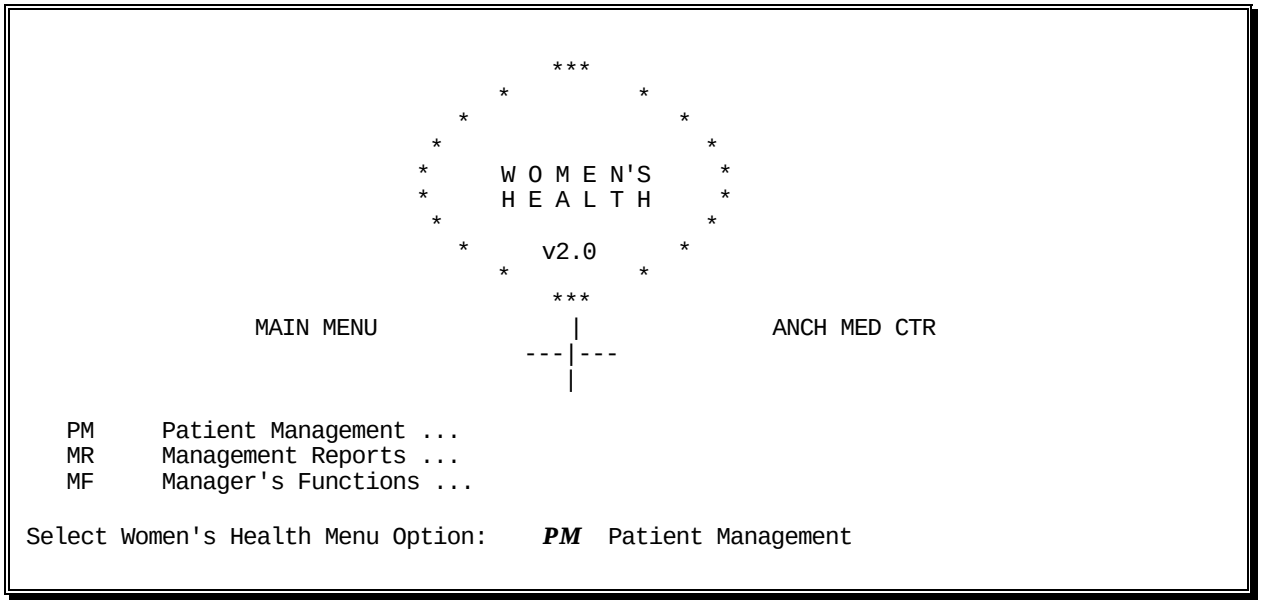



figure 2

2) Enter "PM" (no quotes) and press RETURN, then enter "AP" and press RETURN.

Follow the example Printscreen in figure 3 on the next page:

At the “Select Patient:” prompt, enter a patient’s name or chart #, and press RETURN.
*Note: If the patient you select is not yet in the Women’s Health database, the program will
ask if you wish to add her to the Women’s Health database. Answer “yes”, and continue.

At the “Select Procedure:” prompt, select PAP Smear by just pressing RETURN.
At the “Select Date:” prompt, enter the date of the PAP Smear and press RETURN.

```
            * * *  WOMEN'S HEALTH: ADD A NEW PROCEDURE  * * *


  Select PATIENT:     DEMO,PATIENT            F 12-01-60 650726022 ANMC 54
  Select PROCEDURE: PAP SMEAR//           PS
  Select DATE:      TODAY//   APR 25, 1995
```

figure 3

3) After selecting the date, your screen should look similar to figure 4 below:

```
                      * * *  EDIT A PROCEDURE  * * *

Patient Name: DEMO,PATIENT (34y/o)                   Chart#: 00-00-54
Case Manager: FUDD,ELMER J.                       Procedure: PAP SMEAR
Cx Tx Need  : Repeat PAP (by JUL 07,1995)              Acc#: PS95-24
PAP Regimen : Pqy (annually) (began OCT 01,1994)
Br Tx Need  : Mammogram, Screening (by MAR 21,1995)
------------------------------------------------------------------------------
     Date of Procedure: APR 25,1995          PCC     Date/Time: APR 25,1995@12:00
    Clinician/Provider:   CRAMDEN,RALPH
  Ward/Clinic/Location:   FAMILY MEDICINE (PRINCIPAL)
  Health Care Facility:   ANCH MED CTR
      Clinical History:
    Complete by (Date): MAY 25,1995
     Results/Diagnosis:   WNL/Normal                    Results Text (WP):
 Sec Results/Diagnosis:                                HPV:
                 Status:   CLOSED
_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^CAPTION' to jump to a field in the current window.

COMMAND:
```

figure 4

4) Enter a Provider, Location, Facility and Result by typing your choices and pressing Enter a Provider, Location, Facility and Result by typing your choices and pressing RETURN after each selection. Use the "?" as needed. At the "Status:" line, type "C" (for closed), RETURN. You will now be on the Command Line**.** Type "E" (for Exit), RETURN, and then "Y" (for Yes, save), RETURN. The next screen will be the "Procedure Follow up Menu". Do not make any selection, just press RETURN. You have now entered a PAP Smear Procedure for this patient.

## *Print a Patient Profile*

5) Continuing with the example above, you will have returned to the Patient Management Menu shown in figure 5 below. (To get to this menu from the Main Menu, type "PA" at the Main Menu.)

```
   PC     Edit Patient Case Data
   PP     Patient Profile
   FS     Print Patient Demographic Info (Face Sheet)
   BD     Browse Patients With Needs Past Due
          -------------------------
   AP     Add a NEW Procedure
   EP     Edit a Procedure
   BP     Browse Procedures
   PR     Print a Procedure
   HIS    Add an HISTORICAL Procedure
          -------------------------
   AN     Add a New Notification
   EN     Edit a Notification
   BN     Browse Notifications
   PL     Print Individual Letters
   PQ     Print Queued Letters

Select Patient Management Option:    PP  Patient Profile
```

figure 5

6) Type "PP" (for Patient Profile) and press RETURN.

7) At the “Select PATIENT: ” prompt, enter the same patient you chose above when entering the PAP Smear. At the “Select BRIEF or DETAILED: ” prompt, just press RETURN for BRIEF. At the “Select DEVICE: ” prompt type HOME and press RETURN. See example in figure 6 below:

```
             * * *  WOMEN'S HEALTH: PATIENT PROFILE  * * *


  Select the patient whose Profile you wish to display.
  Select PATIENT:     BROWN,SARAH            F 12-01-60 650726022 ANMC 54

  List Patient Profile in BRIEF or DETAILED format?
  Select BRIEF or DETAILED: BRIEF//

  Select DEVICE: HOME//
```

figure 6

8) The screen that appears will look similar to the example in figure 7 below. The Patient Profile screen displays the patient’s Case Data *above* the double-dashed line and the procedures *below* the double-dashed line.

```
********************** CONFIDENTIAL PATIENT INFORMATION ********************


                      * * *  Patient Profile  * * *

Patient Name: DEMO,PATIENT (34y/o)                Chart#: 00-00-54
Case Manager: FUDD,ELMER J.                     Facility: ANCH MED CTR
Cx Tx Need  : Repeat PAP (by 07/07/95)
PAP Regimen : Pqy (annually)(began 10/01/94)
Br Tx Need  : Mammogram, Screening (by 03/21/95)
==============================================================================

     DATE      PROCEDURE  RESULTS/DIAGNOSIS                          STATUS
     --------  ---------  ---------------------------                 ------
  1) 04/25/95   PAP       WNL/Normal                                  CLOSED

   Press RETURN to continue or '^' to exit, or
```

figure 7

9) Press RETURN twice to return to the Main Menu.

# Setup

## *Overview - The File Maintenance Menu*

Several features of RPMS Women's Health can be customized by the Program Manager. (See page 7 for a description of the Program Manager.) These features include such items as the text of form letters, the types of Notifications and their synonyms, how and when letters get printed, several defaults relating to dates, and options that appear on some menus.

All of the setup options are located under the "File Maintenance Menu" (see figure 8 below) of the "Manager's Functions" menu. It is recommended that the Program Manager examine all of the options listed in this section ("Setup") before utilizing the software for live patient data. Periodically, the Program Manager should again examine these options for the purpose of fine tuning the software to the needs of the site.

```
   WOMEN'S HEALTH:       *  FILE MAINTENANCE MENU  *        ANCH MED CTR
                         ============================


   AEP    Add/Edit a Notification Purpose & Letter
   PPL    Print Notification Purpose & Letter File
   ESN    Edit Synonyms   for Notification Types
   OUT    Add/Edit Notification Outcomes
          -------------------------
   ESP    Edit Site Parameters
   CM     Add/Edit Case Managers
   TR     Transfer a Case Manager's Patients
          -------------------------
   PRD    Print Results/Diagnosis File
   ESR    Edit Synonyms for Results/Diagnoses
   PSR    Print Synonyms for Results/Diagnoses
   EDX    Edit Diagnostic Code Translation File
   PDX    Print Diagnostic Code Translation File


Select File Maintenance Menu Option:
```

figure 8

The top group of options relates to Notifications. The middle group addresses package-wide parameters. And the bottom group relates to Procedures and their Results.

## *Notifications*

### Add/Edit a Notification Purpose & Letter

While Notifications may be phone calls or conversations, most Notifications will be letters and most of the customizable parameters relate to Notifications in the form of letters.

The top option "AEP Add/Edit a Notification Purpose & Letter" allows the Program Manager to add or edit Purposes of Notification, for example, "PAP Result Normal" or "PAP, annual due". Each Purpose of Notification can have its own Form Letter, for example, the Form Letter for "PAP Result Normal" would include a body of text informing the patient that the results of her recent PAP test were normal. When printed, the Form Letter automatically includes the patient's name and address information. The position of the name and address can be adjusted in order to have that information appear in the window of a windowed envelope.

The patient's name, address, and Chart# appear automatically within the letter and are called *fields*. Fields are demarcated by vertical bars: "| |". Other fields that appear are the clinic name and address and the date (as |TODAY|). These fields exist in the Form Letter in a very specific syntax and must not be changed, except for changing the clinic name and address text at the top of the letter; in this case, change only the text within the quotes. Other fields may be deleted if not needed.

Because of the specific syntax of the *fields* and the possibility of corrupting them during edits, a recovery utility has been provided: The program to edit a Purpose of Notification always asks first if you wish to replace the existing Form Letter with a "generic sample letter" (see figure 9 below). Answering "YES" to that question will replace the existing Form Letter with a generic sample letter, which will include all of the original *fields* in their proper syntax.

```
    * * *  WOMEN'S HEALTH: EDIT NOTIFICATION PURPOSE & LETTER FILE  * * *

Select BW NOTIFICATION PURPOSE:    PAP, annual due.         ROUTINE

   Do you wish to delete the old letter for this Purpose of Notification
   and replace it with the generic sample letter?
   Enter Yes or No: NO// ?
```

figure 9

Once the Purpose has been selected and the generic letter question answered, the "Edit Notification Purpose & Letter" screen appears (see figure 10 below).

**NOTE**: For training and assistance in the use of Screens (Screenman) and the Word Processor, please contact your site manager.

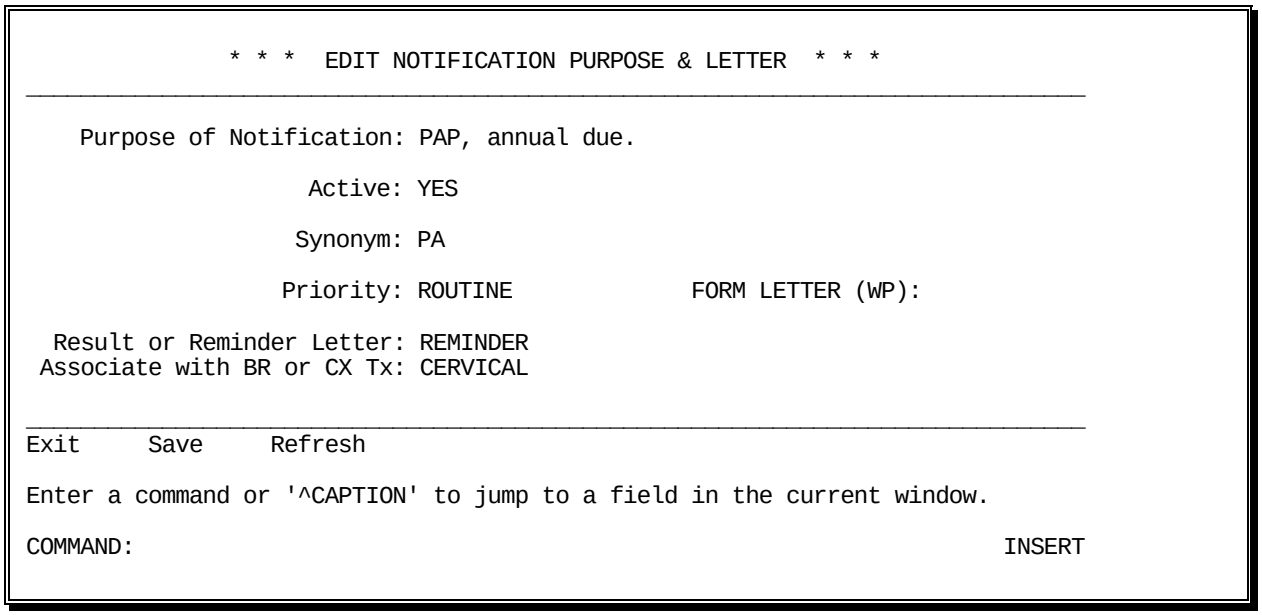



figure 10

All of the fields in figure 10 contain context-sensitive help, which can be displayed by entering a "?" at the prompt. A brief description of each field is listed below:

Purpose of Notification..... The name of this Purpose of Notification. This should be brief but descriptive enough to identify it uniquely. **NOTE: This field cannot be changed.** (Otherwise, *previous* Notifications by this Purpose would become inaccurate.) If the Purpose field is incorrect, make this Purpose "Inactive" (see next field), and then create a new Purpose of Notification with the correct Purpose name.

Active..... "YES": the Purpose may be selected; "NO": the Purpose may not be selected. This is to eliminate the clutter of unused Purposes.

Synonym..... A user-defined 1 to 6 character abbreviation for the Purpose. This is to permit quick selection of a Purpose. These will change from site to site.

Priority ..... Urgent, Asap, and Routine; allows prioritizing a list of Notifications by priority.

Form Letter..... This is the text of the Form Letter for this Purpose of Notification Note: to navigate to this field you must place the cursor at the Priority field and the press the TAB key, then RETURN.

Result or Reminder ..... A Result letter informs the patient of recent results and is queued to print immediately. A Reminder letter informs the patient that it is time to schedule her next appointment and is queued to print weeks or months in the future. This field is used by the software to arrive at a default print date.

Associate with BR/CX ..... Does this Purpose relate to Breast or Cervical Treatment Needs This field is used to arrive at a default print date.

### Print Notification Purpose & Letter File

This option prints out all of the Purposes of Notifications and their field values (Active, Synonym, Priority, etc.) along with the Form Letter. When trying to sort out and edit all the Purposes of Notifications as a coherent group, you may find it easier to print them out on paper (using this option) and work from the stack.

### Edit Synonyms for Notification Types

Notification Types are letters, phone calls, messages, conversations, etc. It is possible to assign synonyms to each Type using this option. For example, "Letter First" might be given a synonym of "LF", "Letter Second", "LS", and so on. This simply provides a user-defined quick method of selecting the desired Type.

### Add/Edit Notification Outcomes

Each Notification, be it a letter, phone call, or other, may be given an "Outcome". Outcomes such as "Declined Tx" and "Scheduled appt for PAP" come pre-loaded with the software. Using this option, it is possible to add other, user-defined Outcomes, such as "Referred to County Hospital".

It is also possible to make a given Outcome "Inactive" if you do not use it and do not wish to have it clutter the list of available choices for Outcome.

## *Site Parameters and Case Managers*

### Site Parameters

The "Edit Site Parameters" option allows the Program Manager to edit several parameters specific to the clinic or hospital where the software is being used. There are 5 PAGES (or screens) of parameters. After selecting a site (or "Facility"), the screen for PAGE 1, shown in figure 11a, appears:

```
            * * *  EDIT SITE PARAMETERS FOR ANCH MED CTR * * *
_____________________________________________________________________________


         Default Case Manager: FUDD,ELMER J.
             Ask Case Manager: NO

  Autoqueue Normal PAP Letters: YES
      PAP Result Normal Letter: PAP result normal, next PAP 1 year.
  Autoqueue Normal MAM Letters: YES
      MAM Result Normal Letter: MAM result normal, next MAM 1 year.

 Default #days to print letter: 30
Ask CBE on Proc Follow-up Menu: YES

                Type of Agency: IHS                      (PAGE 1 OF 5)
_____________________________________________________________________________
```

figure 11a

All of the fields in figure 11a, b & c contain context-sensitive help, which can be displayed by entering a "?" at the prompt. A description of each field is listed below:

Site/Facility Name..... The name of the site where RPMS Women's Health is being run.

Default Case Manager..... The name of the person who will be Case Manager for the majority of patients.

Ask Case Manager..... For various reports, it is possible to select for a particular Case Manager, but only if this is set to "YES". Smaller sites with only one Case Manager would set this to "NO".

Autoq Normal PAP Letters... If "YES", and if the Procedure is a PAP, and if the result is normal, then the option to automatically queue a PAP Result Normal letter will be presented on the Procedure Follow-up Menu. The letter will be queued to print and the Notification will be closed. (see Status on page51)

PAP Result Normal Letter.... Allows Program Manager to choose the PAP Result Normal Letter from the Purpose of Notification table.

Autoq Normal MAM Letters..... If "YES", and if the Procedure is a MAM, and if the result is normal, then the option to automatically queue a MAM Result Normal letter will be presented on the Procedure Follow-up Menu. The letter will be queued to print and the Notification will be closed (see Status on page 51).

MAM Result Normal Letter..... Allows Program Manager to choose the MAM Result Normal Letter from the Purpose of Notification table.

Default #days to print letters..... Allows the Program Manager to set the default number of days each type of Procedure is allowed to remain open before being listed as delinquent. For example, the default for PAPs may be 30 days, but for colposcopies only 14 days, and mammograms only 5 days.

Ask CBE on Follow-up Menu..... If "YES", an option to add a Clinical Breast Exam will appear on the Procedure Follow-up Menu. This is simply for convenience at sites where a CBE is routinely done with a PAP (see page 45).

Type of Agency..... This refers to the agency using the program The choices are either IHS, VA or State. The main effect of this parameter, if it is set to "VA", is to display the patient's Social Security Number instead of the Chart# on all screens, printouts and letters. For now, STATE *behaves identical to* VA; however, in the future this parameter may be used to control additional features. NOTE: If the Type of Agency is set to VA or State, then anywhere in this manual that "Chart#" is shown to appear, "Chart#" will instead be replaced by "SSN" and followed by the patient's social security number.

After selecting a Type of Agency, the cursor will drop to the Command Line. Selecting a "N" (for Next PAGE) at the command prompt will display PAGE 2, as shown in figure 11b:

```
            * * *  EDIT SITE PARAMETERS FOR ANCH MED CTR * * *
_____________________________________________________________________________

    CDC......:  CDC Export: YES     FIPS County Code: 999
                                    FIPS Program Code: 92
                                    CDC Tribal Pgm Abbreviation: SO
                                    Date CDC Funding Began: JAN 1,1995

    HFS......:  Host File Path: /usr2/ihs/pub
    RADIOLOGY:  Import Mammograms from Radiology: NO
                Status Given to Imported Mammograms: OPEN

    PCC......:  Run PCC Link in Diagnostic Mode: YES
                                                          (PAGE 2 OF 5)
_____________________________________________________________________________
```

figure 11b

A description of each field is listed below:

CDC Export..... This is set to yes for all CDC-funded sites. If yes, then FIPS County and Program Codes, CDC Tribal Pgm Abbreviation, and Data CDC Funding Began must be entered according to information provided by CDC. If No, you will bypass these fields.

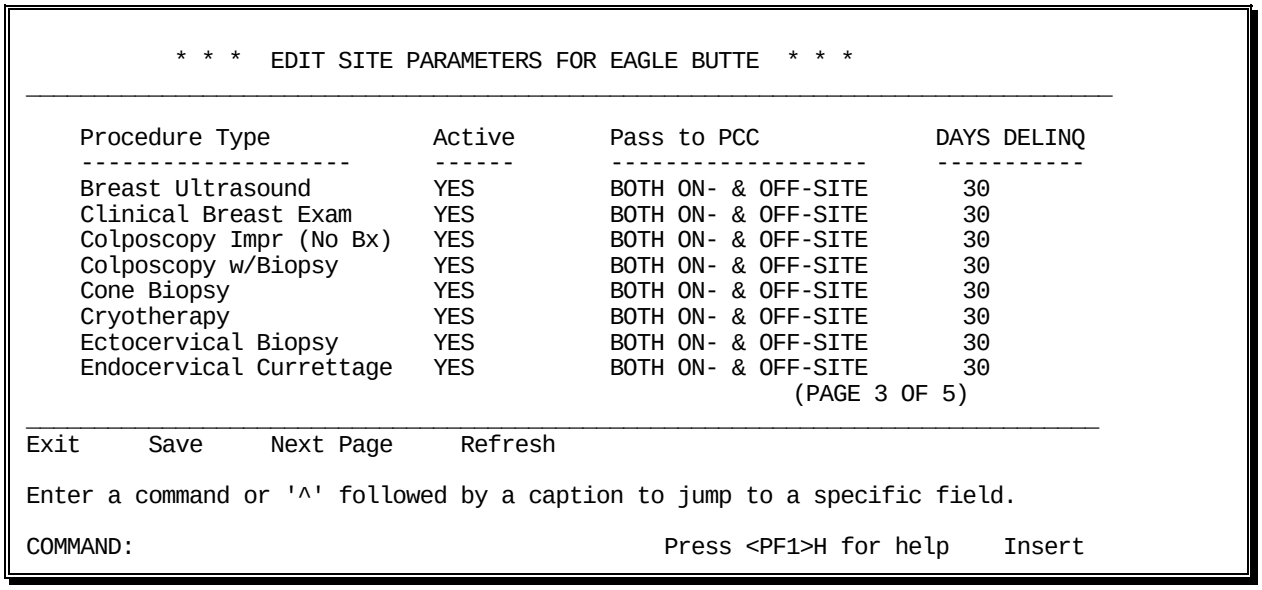
Host File Path ..... This is the host file directory where the Women's Health Software exports and imports files. The CDC export of MDE data will write the export file out to this directory. The utility to import (or "upload") data from Corning Clinical Labs will look for the file to be read in this directory.

Import Mammograms from Radiology..... This field is set to "YES" if you are currently running the IHS Radiology Package and want the Mammogram data from Radiology to be imported into the Women's Health Package.

Status Given to Imported Mammograms..... This field sets the Status of the imported Mammograms. Generally this is set to open so that you can review the results before closing them.

Run PCC in Diagnostic Mode..... If set to YES, error text will be displayed during the transmission of data to PCC files if an error occurs.

After answering the PAGE 2 site parameters, the cursor will drop to the Command Line. Selecting a “N” (for Next PAGE) at the command prompt will display PAGE 3, as shown below in figure 11c. PAGES 3, 4 and 5 all concern setting the parameters for each of the 24 Procedure Types.



```
          * * *  EDIT SITE PARAMETERS FOR EAGLE BUTTE  * * *
_____________________________________________________________________________

    Procedure Type            Active       Pass to PCC             DAYS DELINQ
    --------------------      ------       -------------------     -----------
    Breast Ultrasound         YES          BOTH ON- & OFF-SITE       30
    Clinical Breast Exam      YES          BOTH ON- & OFF-SITE       30
    Colposcopy Impr (No Bx)   YES          BOTH ON- & OFF-SITE       30
    Colposcopy w/Biopsy       YES          BOTH ON- & OFF-SITE       30
    Cone Biopsy               YES          BOTH ON- & OFF-SITE       30
    Cryotherapy               YES          BOTH ON- & OFF-SITE       30
    Ectocervical Biopsy       YES          BOTH ON- & OFF-SITE       30
    Endocervical Currettage   YES          BOTH ON- & OFF-SITE       30
                                                        (PAGE 3 OF 5)
_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                      Press <PF1>H for help    Insert
```

figure 11c

A description of each field is listed below:

Procedure Type ..... This is not an editable field. It simply lists all of the Procedure Types that are available for tracking in the Women’s Health Package.

Active..... If users should NOT be allowed to select the Procedure Type when entering new procedures at this site, then enter "NO" to make it INACTIVE. Enter "YES" to make the Procedure Type ACTIVE.

Pass to PCC ..... Enter "ON" to pass to PCC only procedures done ON-SITE (at this facility). Enter "OFF" to pass only those done OFF-SITE (not done at this facility). Enter BOTH for ON and OFF-SITE procedures. Or enter NEITHER to not pass the procedure to PCC.

Days Delinquent..... Enter the DEFAULT number of days that a procedure of this Procedure Type will be allowed to remain "OPEN" before being marked as "DELINQUENT".

PAGES 4 and 5 of the Edit Site Parameters screen are similar to PAGE 3 and permit the configuration of the remaining Procedure Types.

### Add/Edit Case Managers

The “Add/Edit Case Managers” option allows Case Managers to be selected from the New Person File. If a person you wish to add as a Case Manager cannot be selected, contact your site manager. Under this option a Case Manager may also be inactivated by entering a date at the “DATE INACTIVATED: ” prompt. A Case Manager who has been inactivated cannot be assigned to patients.

### Transfer a Case Manager’s Patients

The purpose of this utility is to aid in the transfer of *all* of one Case Manager’s patients to another Case Manager, such as when there is a turnover in staff. The program will ask you for an “OLD” Case Manager and then for a “NEW” Case Manager. All patients who were previously assigned to the "OLD" Case Manager will be reassigned to the "NEW” Case Manager.

If the “NEW” Case Manager you are looking for cannot be selected, that person must first be added to the file of Case Managers by using the "Add/Edit Case Managers" option.

## *Procedures*

### Print Results/Diagnosis File

For each Procedure Type in RPMS Women’s Health, only certain Results or Diagnoses may be selected. The “Print Results/Diagnosis File” option lists in a tabular form all of the Procedures Types and their corresponding Results/Diagnoses. The report includes a listing of Results by priority as well. These Results/Diagnoses correspond with the Bethesda Classification system for PAP smears and the American College of Radiology for mammograms.

### Edit Synonyms for Results/Diagnoses

You may enter a synonym for each Result/Diagnosis. The synonym will allow the Result/Diagnosis to be called up by typing only a few unique characters. Synonyms should be unique and less than 6 characters. For example, "C1" might be used for CIN I/mild dysplasia; "C2" for CIN II/moderate dysplasia; "C3" for CIN III/severe dysplasia, and so on.

### Print Synonyms for Results/Diagnoses

The “Print Synonyms for Results/Diagnosis File” option lists in tabular form all of the Synonyms and their corresponding Results/Diagnoses.

### Edit Diagnostic Code Translation File

When mammograms are imported from the IHS Radiology package, the diagnoses they are given in the Radiology package must be matched with the corresponding diagnoses in the Women's Health package. This option allows you to correctly match the diagnoses between the two packages. The first prompt allows you to select a Women's Health Diagnosis; the second prompt allows you to select the corresponding Radiology Diagnostic Code. (Note: IHS Radiology is not currently an officially released package.)

### Print Diagnostic Code Translation File

The "Print Diagnostic Code Translation File" option lists all of the Women's Health Mammogram Diagnoses followed by the corresponding Radiology Diagnostic Codes.

## *VA/State as Type of Agency*

### VA Site

When this software is used at a VA facility, the Type of Agency (see page 22) site parameter should be set to VA. The main effect of this parameter is to display the patient's Social Security Number instead of the Chart# on all screens, printouts and letters.

Another important difference is that any options which display the IHS Face Sheet (demographic data from the IHS Registration software) will not display the IHS Face Sheet if the Type of Agency is set to VA; instead, a note of explanation that the IHS Face Sheet is unavailable to VA sites will be displayed. VA programmers or site managers may want to alter this by inserting a call to a VA routine that displays patient demographics. This can be done by editing the routine ^BWFACE at line label FACE+13. Comments are included at that point in the routine to make it clear where the call to a VA patient demographic routine should be inserted.

Some reports in the software offer to select for a "Current Community", which is a field in the IHS Registration software. This prompt will not appear at VA sites.

A final note: In order for the IHS Women's Health software to operate, a complete Data Dictionary of the IHS Patient file #9000001 is required (approximately 95 fields). The Special Lookup and Post Selection Action routines for file #9000001 and *not* required for the IHS Women's Health package.

### State Site

When this software is used at a State facility, the Type of Agency (see page 22) site parameter can be set to either IHS, VA or State, depending on whether the state is using IHS Patient Registration or VA Patient Registration. For now, STATE *behaves identical to* VA, as described in the preceding section. In the future, however, this parameter may be used to control additional features specific to states.

## *Patient Profile for Other Users/Menus*

An option has been provided for users--clinicians, providers and other healthcare staff--to view a patient's Women's Health profile from other menus *outside of* the Women's Health package. The option does not allow edits to the patient's procedures. It displays the Patient Profile exactly as described under Patient Profile on page 33. However, if a Procedure is selected from the Profile, instead of presenting the "Edit a Procedure" screen, the software simply displays or prints the Procedure in a manner identical to the "Print a Procedure" option (see page 47).

The text of the option appears as "Women's Health Patient Profile". ("Women's Health" is added to "Patient Profile" so that the option will be easily identified and understood when it appears on menus outside of the Women's Health package. The option is located on the Manager's Patient Management menu (see page 61) so that it can be easily located and reviewed by the Program Manager and the site manager. When placing this option on another menu, the option name to use is "BW PATIENT PROFILE USER". Contact your site manager for assistance in placing this option on other users' menus outside of the Women's Health package.

# Menus and Options Described

## *Overview*

Like all RPMS software, the RPMS Women's Health software is composed of a main menu, several submenus, and *options*. An "option" is one of the items presented on a menu. An option is selected by typing the name of the option or by typing the 2-to-4 character synonym that appears in the column to the left of the option names, and then pressing RETURN. Some options will bring up submenus of more options, which are grouped together by the type of function they perform. Most options simply perform a single function, such as "Add/Edit a Procedure" or "Print Queued Letters".

Not all options are available to all users. Some options require special knowledge or display confidential information. These options may be locked with *keys* that are given only to certain staff, such as the Program Manager. It may be that not all of the options described in this User Manual appear on your screen, possibly because you have not been given the *key* to that particular option. If you have questions regarding *locked* options or questions in general regarding how to navigate through RPMS menus, please contact your site manager.

The Main Menu shown in figure 12 below is made up of three options: **Patient Management**, **Management Reports**, and **Manager's Functions**. (Manager's Functions is a *locked option* and might not appear on your menu.) Each of these three options represent a sub-menu, with further options beneath it. The remainder of this manual will be devoted to describing these submenus and their options.

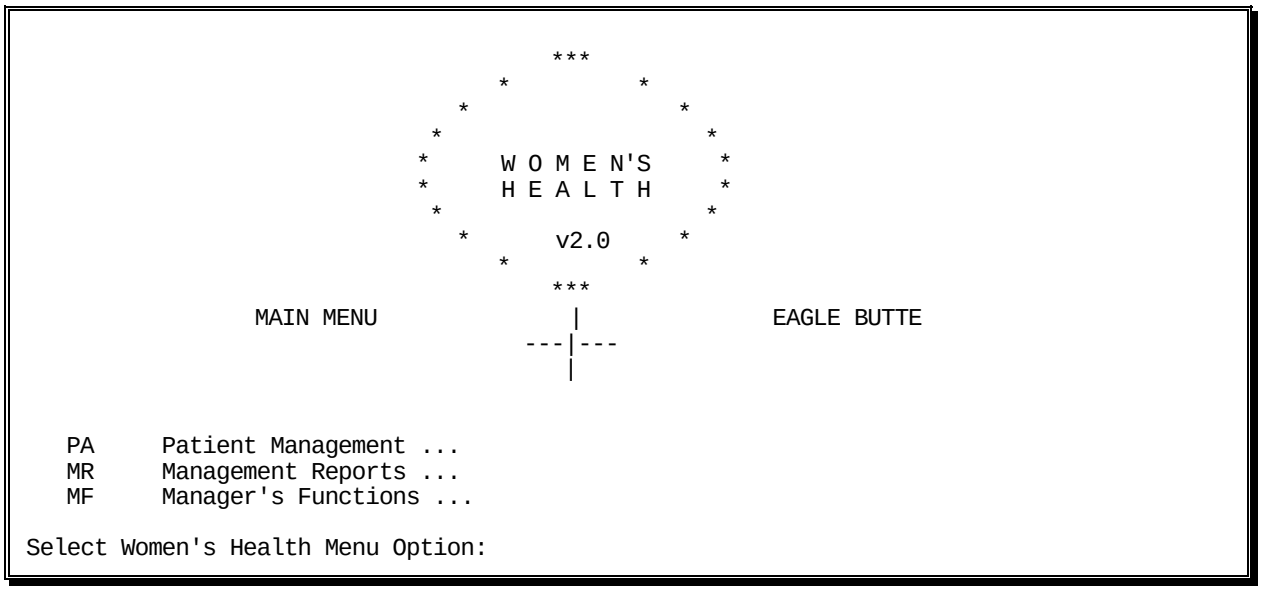



figure 12

## *Patient Management Menu*

### Overview

The Patient Management Menu shown in figure 13 below is divided into three groups of options: the Patient options (top), the Procedure options (middle), and the Notification options (bottom).

```
WOMEN'S HEALTH:      *  PATIENT MANAGEMENT MENU  *       EAGLE BUTTE
                     ============================


   PC     Edit/Print Patient Case Data
   PP     Patient Profile
   FS     Print Patient Demographic Info (Face Sheet)
   BD     Browse Patients With Needs Past Due
          --------------------------
   AP     Add a NEW Procedure
   EP     Edit a Procedure
   BP     Browse Procedures
   PR     Print a Procedure
   HIS    Add an HISTORICAL Procedure
          -------------------------
   AN     Add a New Notification
   EN     Edit a Notification
   BN     Browse Notifications
   PL     Print Individual Letters
   PQ     Print Queued Letters

Select Patient Management Option:
```

figure 13

### Patient Options

The top group of options relate mainly to managing Patients. Under the Edit Patient Case Data you can enter Register data such as Case Manager, Breast and Cervical Treatment needs and due dates as well as the PAP Regimen. From the "Patient Profile" option it is possible to look at all of the Procedures and Notifications associated with an individual patient and to edit those items, as well as edit the patient's Case Data. “Display/Print Patient Face Sheet” is an option from the Registration Package that gives patient demographic and third party billing data. Under the "Browse Patients..." option it is possible to search for and browse through patients whose Treatment Needs are past due.

## Procedure Options

The middle group of options relates more directly to working with Procedures. The first two options allow the adding and editing of Procedures. Under the "Browse Procedures" option it is possible to search for and print Procedures based on selected criteria. A series of questions, with available help, guide the user through the selection process. The “Print a Procedure” option will print all of the information relating to a single procedure. The “Add an Historical Procedure” option allows entering a minimum of data for procedures done in years past in order to make the patient’s profile more complete.

## Notification Options

The bottom group relates mostly to working with Notifications. The first two options allow the adding and editing of Notifications. Under the "Browse Notifications" option it is possible to search for and print Notifications based on selected criteria. The last two options allow for the printing of individual letters and all letters that are queued to print.

For convenience and ease of workflow, many of the edit screens for working with Procedures and Notifications will also be available when you are working under the Patient Options. For example, when viewing the Patient Profile you will be able to select procedures and notifications for editing. The remainder of this section will describe each of the options under the Patient Management Menu.

**NOTE**: For training and assistance in the use of Screens (Screenman) and the Word Processor, please contact your site manager.

**Edit/Print Patient Case Data**

This option allows you to add a new patient and her Case Data to the RPMS Women's Health register. It also allows you to edit the Case Data of patients already in the register. When you add or edit a patient's Case Data, you will be presented with the "Edit Patient Case Data" screen (see figure 14 below).

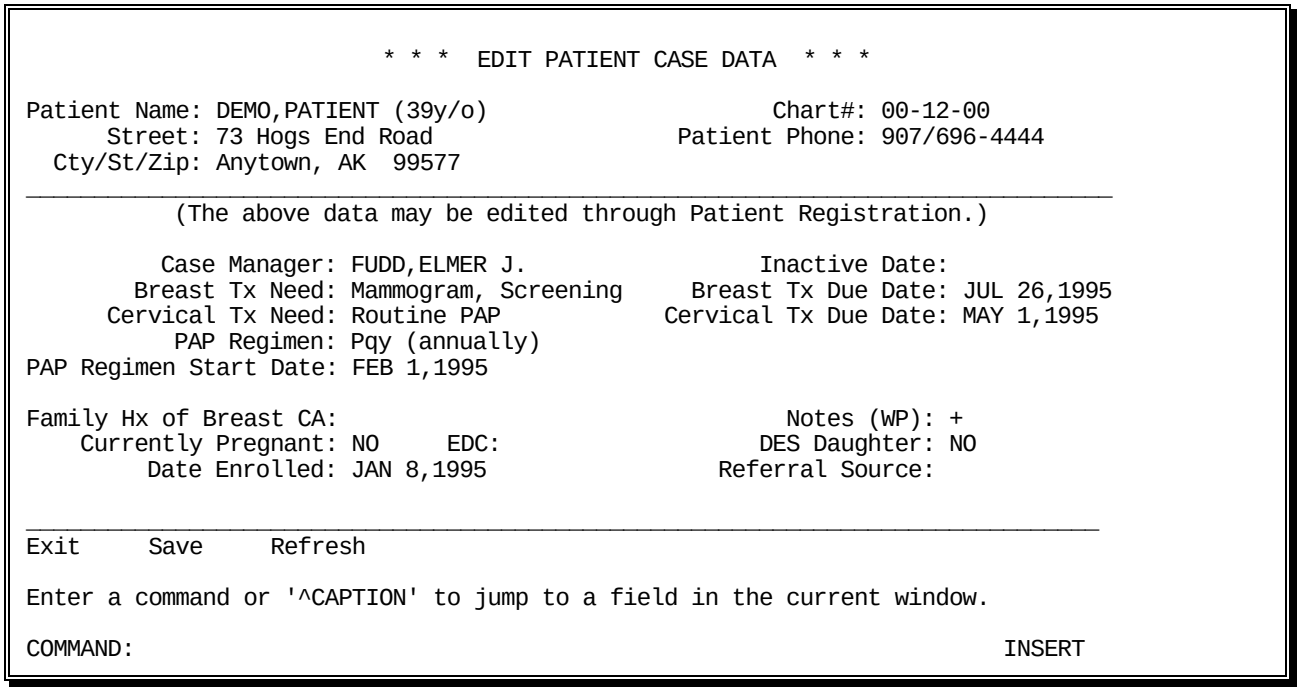



figure 14

All of the fields in figure 14 contain context-sensitive help, which can be displayed by entering a "?" at the prompt. Brief descriptions of each field are listed below.

The fields in the top third of the screen are editable only through the Registration module.
If the Type of Agency site parameter (see page 22) is set to VA or State, SSN instead of Chart# will appear in the top right-hand corner. If the CDC Export site parameter (see page 23) is set to YES, a "Unique ID" field will appear under the Patient Phone field. The Unique ID is used only by the CDC export utility and is automatically assigned to each patient by the software.

Case Manager ..... This is the person who is currently managing this patient's Breast and Cervical Treatment Needs, entering the data on her procedures, queuing letters to her, etc. Note: All case managers must be entered by the Program Manager under the File Maintenance Menu.

Breast Treatment Need..... The current or next breast study procedure needed for this patient i.e. Clinical Breast Exam, Screening Mammogram, Diagnostic Mammogram.

Breast Tx Due Date..... Date by which this Breast Tx Need should be completed. Reports run after this date will include this patient as having a Breast Tx Need past due.

Cervical Treatment Need..... The current or next cervical procedure needed for this patient i.e. PAP Smear, Colposcopy.

Cervical Tx Due Date..... Date by which this Cervical Tx Need should be completed. Reports run after this date will include this patient as having a Cervical Tx Need past due.

PAP Regimen..... This is the PAP regimen for the patient. The regimen appears in an abbreviated form so that it can be listed on several screens where there is limited space. The following abbreviations apply:

| symbol | meaning |
|---|---|
| P | PAP |
| C | colposcopy |
| wk | week |
| m | month |
| y | year |
| q | every |
| pp | postpartum |
| x2 | times 2 |
| x3 | times 3 |
| ga | gestation |

The abbreviations read much like a prescription. For example, "Pq6mx2, Pqy" stands for "PAP every 6 months times 2, then PAP every year (annually)". Another example, "P6wkpp, C8-12wkpp" stands for "PAP at 6 weeks postpartum, then colposcopy 8 to 12 weeks postpartum".

PAP Regimen Start Date..... The date on which the patient began or will begin the current PAP Regimen.

Family Hx of Breast CA..... Enter the code for the relatives of this patient who have had breast cancer. (1st degree relative is a sister/mother, 2nd degree relatives are extended family.) Choose from: 0 - no family history, 1 - 2nd degree relative, 2 - 1st degree relative, 3 - >1 1st degree relatives.

Notes (WP)..... A word processing field that can be used to store any additional information. If there is a "+" in this field it indicates that there is information present. This information does not appear on any report.

Currently Pregnant..... Enter "yes" if the patient is pregnant.

EDC..... Due date if pregnant (Estimated Date of Confinement).

DES Daughter..... Enter "yes" if the patient's mother took DES when she was pregnant with this patient.

Date Enrolled..... This field is used by CDC sites and should contain the Date that the patient was enrolled in their program.

Referral Source..... This field is used by CDC sites. The choices for this field are: Self, Provider, Other or Unknown.

After exiting the "Edit Patient Case Data" screen you will be given the opportunity to print the patient's Case Data to a DEVICE.

**Patient Profile**

This option allows you to look at all of the Procedures and Notifications associated with an individual patient and to edit those items, as well as edit the patient's Case Data. If you choose the Brief format, only the patient's Procedures will be listed. If you choose the Detailed format, both Procedures and Notifications, as well as PAP Regimen changes and pregnancies will be listed. The screen displayed below in figure 15 is an example of the Brief format, displaying only Procedures.

```
                * * *  WOMEN'S HEALTH: PATIENT PROFILE  * * *

   Select the patient whose Profile you wish to display.
   Select PATIENT:      DEMO,PATIENT          F 12-01-53            EB 999999

   List Patient Profile in BRIEF or DETAILED format?
   Select BRIEF or DETAILED: BRIEF//

   Select DEVICE: HOME//

********************** CONFIDENTIAL PATIENT INFORMATION **********************

                         * * *  Patient Profile  * * *

Patient Name: DEMO,PATIENT (41y/o)                  Chart#: 99-99-99
Case Manager: FUDD,ELMER                          Facility: EAGLE BUTTE
Cx Tx Need  : Routine PAP (by 02/18/95)
PAP Regimen : Pqy (annually) (began 02/18/95)
Br Tx Need  : Mammogram, Screening (by 02/18/95)
==============================================================================
      DATE      PROCEDURE  RESULTS/DIAGNOSIS                          STATUS
      --------  ---------  ---------------------------                ------
  1)  02/23/95   HCG       Positive                                   DELINQ
  2)  02/23/95   STD       Positive                                   OPEN
  3)  02/21/95   PAP       WNL/Normal                                 OPEN
  4)  02/20/95   PAP       WNL/Normal                                 CLOSED

   Press RETURN to continue or '^'to exit, or
   Select a left column number to edit:  (1-4):
```

figure 15

The patient's Case Data is shown above the double-dashed line, while the Procedures, their dates, results, and status are shown below. If the Device selected for the Patient Profile is "HOME" (to the screen), a column of numbers will appear to the left of the Procedures (and of the Notifications in the Detailed report). If you select one of these numbers at the prompt, you will enter the edit screen for that Procedure or Notification. Working through the Patient Profile in this way is a convenient method of editing Procedures and Notifications while having a total picture of the patient's history at hand.

Alternatively, the Patient Profile may be sent to a printer. NOTE: For help in answering the "Select DEVICE: " prompt, please contact your site manager.

**Print Patient Demographic Info (Face Sheet)**

This option allows you to display or print patient demographic information. (For IHS sites this is the Face Sheet.) It provides information such as the patient's address, phone numbers, spouse, emergency contacts and billing information. Figure 16 below is an example of a Face Sheet. If the Type of Agency site parameter (see page 22) is set to VA or State, the display may be somewhat different from the IHS Face Sheet. Contact your site manager for questions regarding the VA/State display of patient demographic information. (Also see page 26.)

```
                    *** CONFIDENTIAL PATIENT INFORMATION ***
                                EAGLE BUTTE
                          AMBULATORY CARE RECORD BRIEF
                         ------------------------------
APR 06, 1995@08:23:21                                                    Page: 1
================================================================================
PATIENT: DEMO,RAMONA RAE                              CHART #: 0001
================================================================================
COMPUTER FILE EST: APR 17, 1986                   LAST EDIT: FEB 10, 1995 (CL)
--------------------------------------------------------------------------------
SSN: 123-45-6789                        SSN STATUS: Verified by SSA
CLASS: INDIAN/ALASKA NATIVE                                   SEX: FEMALE
COMMUNITY: EAGLE BUTTE                                 BIRTHDAY: JUN 10, 1947
   COUNTY: DEWEY                                             AGE: 47 YRS
HOME ADDRESS:
     BOX 000
     EAGLE BUTTE, SOUTH DAKOTA 57625
  HOME PHONE: 555-3145                  OFFICE PHONE: 555-3010
--------------------------------------------------------------------------------
TRIBE: SIOUX, CHEYENNE RIVER TRIBE                INDIAN QUANTUM: 7/16
BIRTHPLACE: CHEYENNE AGENCY, SOUTH DAKOTA
RELIGION: CATHOLIC                                TRIBE ENROLL #:
--------------------------------------------------------------------------------
FATHER: DEMO,CLIFFORD,SR                BIRTHPLACE:  SD
MOTHER: DOE,CATHERINE                   BIRTHPLACE:  SD
--------------------------------------------------------------------------------
EM CONTACT: DEMO,MIKE   (HUSBAND)                  EM PHONE: 555-3145
EM ADDRESS:
     BOX 000
     EAGLE BUTTE, SOUTH DAKOTA 57625
--------------------------------------------------------------------------------
                       *** THIRD PARTY ELIGIBILITY ***
--------------------------------------------------------------------------------
PRIVATE INSURANCE:
INS. COMPANY                 NUMBER           ELIG. DATE    ELIG. END DATE
THE GUARDIAN GROUP INS.      123-45-6789      FEB 01, 1995
--------------------------------------------------------------------------------
PATIENT'S EMPLOYER: CRST TRIBAL HEALTH
                    PO BOX 590
                    EAGLE BUTTE, SD  EAGLE BUTTE

             PHONE: 555-8918
--------------------------------------------------------------------------------
    ***  ELIGIBILITY FOR CARE: CHS & DIRECT  ***
--------------------------------------------------------------------------------
                     *** CONFIDENTIAL PATIENT INFORMATION ***
```

figure 16

**Browse Patients With Needs Past Due**

This option allows you to search for and browse through patients whose Treatment Needs are past due. The five questions (see figure 17 below) that are asked prior to the display allow you to specify the needs, dates, Case Managers, Current Community, order of display, and Device for the display.

```
* * *  WOMEN'S HEALTH: BREAST & CERVICAL TX NEEDS PAST DUE REPORT  * * *


Include patients whose Breast or Cervical Tx Needs are undetermined?
Enter Yes or No: YES//

Select the date to be checked for patient Tx Needs past due:
Select a date:  TODAY//   (FEB 18, 1995)

Report on all patients for ONE particular Case Manager,
or report on all patients for ALL Case Managers?
Select ONE or ALL: ALL//

You may browse needs for patients living in one or more specific
communities, or you may select all communities.  "Community" in this
context refers to the patient's "Current Community" as displayed and
edited in the IHS Registration software.

Include ALL Current Communities in this listing? Y//

Display Procedures in order of:            1) DATE DELINQUENT (earliest first)
                                           2) PATIENT NAME (alphabetically)
Select 1 or 2: 1//   DATE DELINQUENT

Select DEVICE: HOME//
```

figure 17

All of the prompts in figure 17 contain context-sensitive help, which can be displayed by entering a “?” at the prompt.

NOTE: It may be useful to select a date at some time in the future, for example, two weeks ahead, in order to anticipate which patients *will become* delinquent and to act on those cases ahead of time. Some providers do this in preparation for a field trip to a remote site.

An example of the “Browse Patients With Needs Past Due” option display is shown in figure 18 below. If the Device selected is “HOME” (to the screen), a column of numbers will appear to the left of the chart numbers. If you select one of these numbers at the prompt, you will enter the “Edit Patient Case Data” screen for that patient.

```
********************** CONFIDENTIAL PATIENT INFORMATION **********************

                    * * *  PATIENTS LISTED BY NEED DATE  * * *

Case Mgr: ALL
Facility: EAGLE BUTTE                          Tx Needs Past Due as of 02/18/95
================================================================================
      CHART#    PATIENT            CASE MGR   TREATMENT NEED DUE BY DATE
--------------------------------------------------------------------------------

   1) 99-99-99  DEMO,PATIENT ....  KNIFE        Routine PAP (by 02/18/95)
                                               Mammogram, Screening (by 02/18/95)

   2) 12-34-56  BROWN,SARAH .....  KNIFE        Follow-up PAP (by 02/19/95)
                                               Mammogram, Screening (by 04/18/95)

   3) 33-33-44  BLACK,ALICE .....  KNIFE        Routine PAP (by 01/11/95)
                                               Mammogram, Screening (by 05/08/95)

   4) 77-88-43  SMITH,JOAN ......  KNIFE        Routine PAP (by 02/18/95)
                                               Mammogram, Screening (by 02/18/95)

                         -----  End of Report  -----

Press RETURN to continue or '^' to exit, or
Select a left column number to edit:(1-4):
```

figure 18

**Add a NEW Procedure**

This option allows you to add Procedures for patients. The first prompt asks you to select a patient (either by name, chart #, or CDC ID #). The second prompt asks you to select a Procedure. The possible choices of Procedures are listed in the table below:

Breast Ultrasound - BU
Clinical Breast Exam - CB
Colposcopy Impression (No BX) -CI
Colposcopy w/Biopsy - CO
Cone Biopsy - CN
Cryotherapy - CY
Ectocervical Biopsy - EB
Endocervical Curettage - EC
Endometrial Biopsy - EM
Fine Needle Aspiration - FN
General Surgery Consult - GS
GYN ONC Consult - GY
Hysterectomy - HY
Laser Ablation - LA
Laser Cone - LC
LEEP - LP
Lumpectomy - LM
Mammogram Dx Unilat - MU
Mammogram Dx Bilat - MB
Mammogram Screening - MS
Mastectomy - MT
Needle Biopsy - NB
Open Biopsy - OB
PAP Smear - PS
Pregnancy Test - PT
STD Evaluation - ST
Stereotactic Biopsy - SB

The Procedure is selected by typing either its name or its abbreviated code, for example, “PS” will select “PAP Smear”. (These codes are also used in the Accession Numbers, for example, “PS95-43” will be an Accession# for a PAP Smear.)

If the procedure is a Unilateral Mammogram, an additional prompt will ask you to enter “LEFT OR RIGHT”. If the procedure is a colposcopy, an additional prompt will ask you to select the Accession# of the PAP that initiated this colposcopy.

A final prompt asks you for the date of the procedure. At this point the computer checks to see if this procedure has already been entered for this patient on this date. If so, then this would be a duplicate procedure, and the screen in figure 19 below will appear:

```
           * * *  WOMEN'S HEALTH: ADD A NEW PROCEDURE  * * *

Select PATIENT:   DEMO,PATIENT           F 01-01-56 123731795 ANMC 1200
Select PROCEDURE: PAP SMEAR//           PS
Select DATE:      TODAY//   APR 27, 1995

  A PAP SMEAR already exists for this patient on this date, with
  an Accession# of PS95-862.  You may edit that procedure by
  calling up PS95-862 under the "Edit a Procedure" option.
  Or you may enter another PAP SMEAR for this patient on this date.

  Do you REALLY want to add another PAP SMEAR for this patient
  on this date?
  Enter Yes or No? NO//
```

figure 19

If the above screen in figure 19 appears, then your choices are to either edit the procedure shown by its Accession#, or to change the date of the procedure you’re trying to add.

Once you have added a valid new Procedure, the program will automatically assign the Procedure a unique Accession# and then proceed to the "EDIT A PROCEDURE" screen shown in figure 20 in the next section. The Accession# for a Procedure uniquely identifies that Procedure for all editing and reporting purposes

**Edit a Procedure**

This option allows you to edit Procedures for patients. The first prompt asks you to select an Accession# or Patient name. A patient's Chart# may also be entered. (CDC-funded sites can also enter the Unique ID#.) An Accession# would be of the form "PS95-24". If you know the Accession# of the Procedure you wish to edit, it will be more efficient to select the Procedure by its Accession# rather than by its patient (some patients will have several Procedures on file).

PAGE 1 - ALL PROCEDURES

The screen to enter or edit data for procedures is show in figure 20 below. All of the fields in figure 20 contain context-sensitive help, which can be displayed by entering a "?" at the prompt. **NOTE**: For training and assistance in the use of Screens (Screenman) and the Word Processor, please contact your site manager.

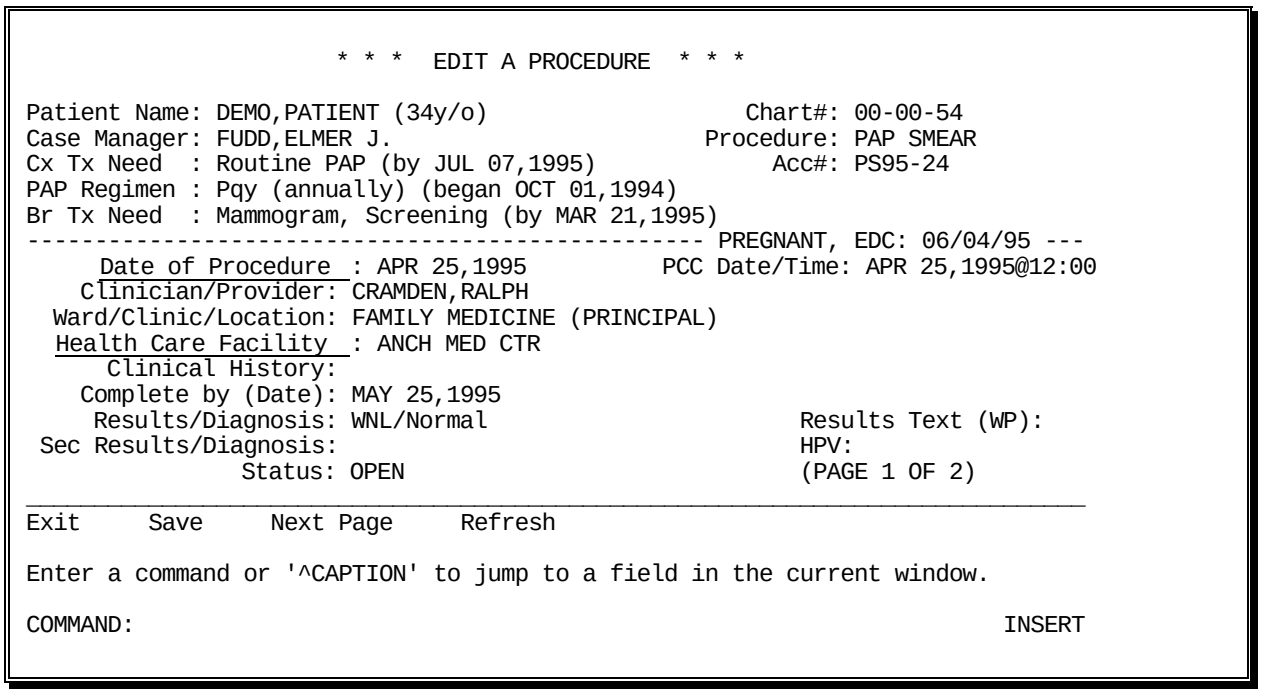



figure 20

The following is a brief explanation of each field in the "EDIT A PROCEDURE" screen:

Fields above dashed line..... These are the Patient's Case Data fields and are not editable in this screen. They may be edited through "Edit Patient Case Data" option.

Date of Procedure..... (required) The date that the procedure was performed.

PCC Date/Time..... An optional field (you must Tab over to it) for entering the date & time from the PCC form. For sites where visits are linked based on time of day.

Clinician/Provider..... The clinician who performed the procedure.

Ward/Clinic/Location..... The ward, clinic, or location where the procedure was performed. This is selected from the Hospital Location file #44. If the clinic you wish to select is not available in this file, contact your site manager. Note: if the entries in file #44 have an Institution fields filled in, the institution will be provide as the default for the next field "Health Care Facility".

Health Care Facility..... (required) This is selected from the Institution (or Facility) file #4. If the Health Care facility you wish to select is not available in this file, contact your site manager.

Clinical History..... An optional one-line clinical history note (limited to 78 characters).

Complete by (Date)..... The date after which a procedure will be delinquent or past due if it has not been Closed under the Status field.

Results/Diagnosis..... Selected from the Results/Diagnosis table. Usually entered when results come back from the lab. A list of the possible Results/Diagnosis for each Procedure Type is found in Appendix A.
*** NOTE: Procedures cannot be deleted.** If a Procedure has been entered in error or is invalid for some other reason, enter a Results/Diagnosis of "**Error/disregard**". Procedures with a Results/Diagnosis of "Error/disregard" will not appear on Patient Profiles, nor will they be included in the various epidemiology reports. These Procedures *can* be viewed only under the "Patient Profile Including Errors" option of the Manager's Patient Management menu.

Sec Results/Diagnosis..... Secondary (or additional) Results/Diagnosis, selected from the Results/Diagnosis table. Usually entered when results come back from the lab.

Results Text (WP)..... The text of the lab report. This is an optional field (you must Tab over to it). Results text for procedures such as PAPs may be downloaded from Corning Clinical labs, however, the process does adhere to any standard protocol. Future versions of Women's Health may provide this capability for HL7 formatted data. If there is text data present, a "+" will appear to the right of the field label, like so: (WP): +

HPV..... Enter "yes" if the lab report includes HPV.

Status..... Select either OPEN or CLOSED. A Procedure is usually left OPEN until the Results/Diagnosis has been entered. A Procedure that is left OPEN past its "Complete by (Date)" (see above) will be displayed as "Delinquent" on Procedure reports. (The Status NEW is assigned to all Procedures that have had a Results Text automatically downloaded from a commercial lab.)

(PAGE 1 OF 2)..... This will not appear in all cases. It will only appear if there is a PAGE 2 of data fields to be edited, such as for a colposcopy-type procedures or, in the case of a CDC-funded site, any PAP or mammogram.

If there is no PAGE 2 of data fields to be edited, then when you have completed the edits for this PAGE you would save and exit this procedure via the Command Line at the bottom of the screen. When you leave the "EDIT A PROCEDURE" screen, you will always be presented with the Procedure Follow-up Menu (see page 43).

PAGE 2 - COLPOSCOPY

Some Procedures, such as Colposcopy, Cone Biopsy, Laser Cone, and LEEP, will have a **PAGE 2** to the "EDIT A PROCEDURE" screen (see figure 21 below). This is indicated by the words "(PAGE 1 OF 2)" just beneath the "HPV:" prompt on PAGE 1. PAGE 2 is concerned with the clinical findings and tissue pathology results of colposcopy and similar procedures.

There are two ways to get to PAGE 2:

1) Hold down the PF1 (or F1 on a PC) key while pressing the "cursor up arrow" key.

or 2) Get to the Command line at the bottom and type "N" for "Next PAGE", and press RETURN.

The same methods work for getting you back to PAGE 1. **NOTE**: For training and assistance in the use of Screens (Screenman) and the Word Processor, please contact your site manager.

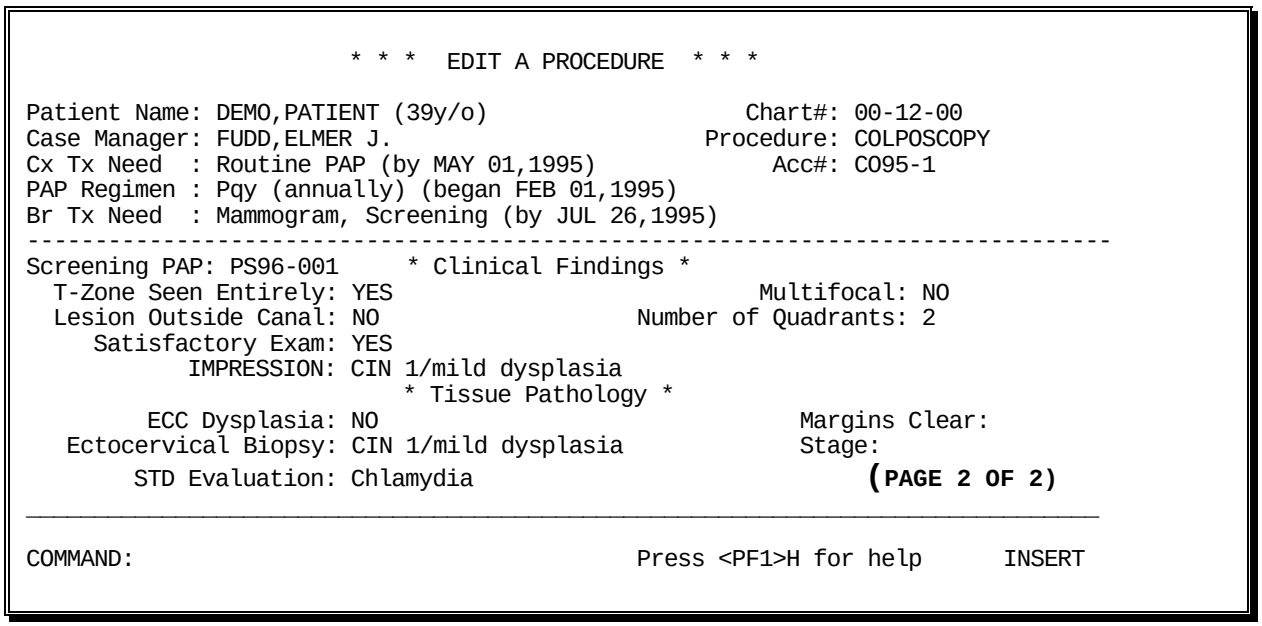



figure 21a

All of the fields in figure 21a contain context-sensitive help, which can be displayed by entering a "?" at the prompt. The Clinical Findings will be found usually on a PCC form or other form used by the OB/GYN physician performing the Colposcopy or Biopsy. The Tissue Pathology report section would be used most commonly for colposcopies in which an ECC and a Biopsy were performed at the same time as the Colposcopy. Therefore, you will NOT need to add separate procedures for a Biopsy and ECC if they are done WITH a Colposcopy.

When you have completed the edits for PAGE 2 of a colposcopy you would save and exit this procedure via the Command Line at the bottom of the screen. When you leave the "EDIT A PROCEDURE" screen, you will always be presented with the Procedure Follow-up Menu (see page 45).

PAGE 2 - CDC EXPORT, PAPS

Sites running in the CDC Export mode (see page 23) will have a **PAGE 2** to the "EDIT A PROCEDURE" screen for all PAPs. This is indicated by the words "(PAGE 1 OF 2)" just beneath the "HPV:" prompt on PAGE 1. PAGE 2 is concerned with the outcome of the current treatment cycle. An example of PAGE 2 for a PAP is shown below in figure 21b:

```
                    * * *  EDIT A PROCEDURE  * * *

Patient Name: DEMO,PATIENT (34y/o)                  Chart#: 00-00-54
Case Manager: FUDD,ELMER J.                      Procedure: PAP SMEAR
Cx Tx Need  : Repeat PAP (by JUL 07,1995)            Acc#: PS95-24
PAP Regimen : Pqy (annually) (began OCT 01,1994)
Br Tx Need  : Mammogram, Screening (by MAR 21,1995)
--------------------------------------------------------------------------------
    Most recent Colp associated with this PAP:  CO95-1 on 11/02/95
                                  Diagnosis:  CIN II/moderate dysplasia
    Diagnostic Workup...:   Planned
    Other Proc Performed:   colposcopy
    Final Dx PAP/Colp...:   CIN I/mild  dysplasia
    Status of Final Dx..:   Workup Complete
    Date of Final Dx....:   OCT 1,1995
    Status of Treatment.:
    Date of Tx Status...:                                          (PAGE 2 OF 2)
________________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^CAPTION' to jump to a field in the current window.

COMMAND:
```

figure 21b

Data for the "Most recent Colp associated with this PAP" is present only if you have added a *separate* colposcopy and *linked it to this particular PAP*. Colposcopies may be linked to PAPs by editing the "Screening PAP" field on PAGE 2 of the colposcopy edit screen.

The following is a brief explanation of each field on the PAGE 2 of the "EDIT A PROCEDURE" screen for PAPs:

Diagnostic Workup..... Indicate whether further diagnostic workup procedures are planned to follow-up on this procedure. Choose from: 1) Planned, 2) Not Planned, or 3) Undetermined. If the result of the PAP was normal or WNL, enter 2 ("Not Planned"). If you leave this field blank for a normal PAP, it will be assumed to be Not Planned on Export.

Other Proc Performed..... Enter the names of any other procedures performed that related to this Abnormal PAP/MAM/CBE. Answer must be 20 characters or less.

Final Dx PAP/Colp ..... Select the Final Diagnosis for this PAP/Colp case.

Status of Final Dx..... Enter the status of the Final Diagnosis. Choose from: 1) Workup Complete, 2) Workup Pending, 3) Lost to Follow-up, or 4) Workup Refused. If a woman dies before workup has started, enter 3, Lost to Follow-up.

Date of Final Dx..... Enter the date that the Final Diagnosis was made. If the patient was lost to follow-up or refused workup, enter the date of closeout of this procedure.

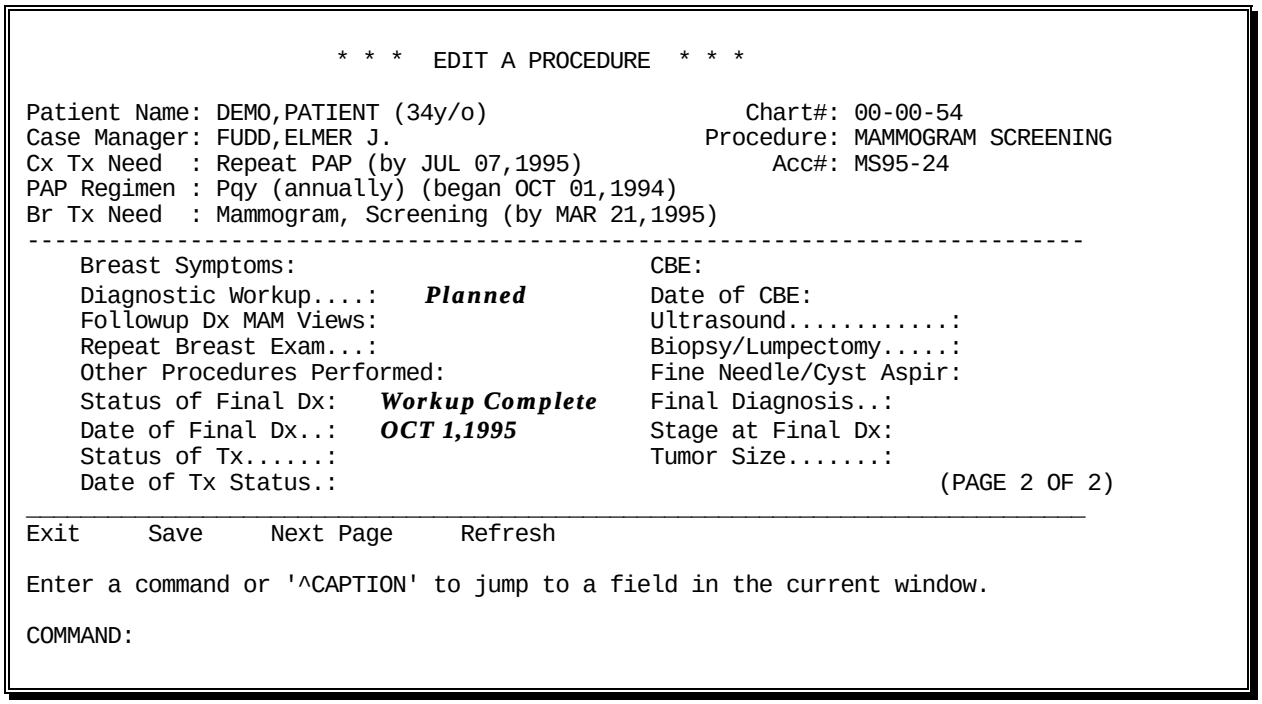
Status of Treatment ..... Enter the current status of treatment for this patient. Choose from: 1) Tx started, 2) Tx pending, 3) Lost to follow-up, 4) Tx refused or 5) Tx not needed. Do not fill this in if the Status of Final Dx is complete. If the woman dies before treatment has begun, enter 3, Lost to follow-up.

Date of Tx Status..... If treatment for cancer has begun, enter the date on which the treatment began. If treatment is pending, leave blank. If this procedure is closed, enter date of closeout.

When you have completed the edits for this PAGE you would save and exit this procedure via the Command Line at the bottom of the screen. When you leave the "EDIT A PROCEDURE" screen, you will always be presented with the Procedure Follow-up Menu (see page 45).

PAGE 2 - CDC EXPORT, SCREENING MAMMOGRAMS

Sites running in the CDC Export mode (see page 23) will have a **PAGE 2** to the "EDIT A PROCEDURE" screen for all Screening Mammograms. This is indicated by the words "(PAGE 1 OF 2)" just beneath the "HPV:" prompt on PAGE 1. PAGE 2 is concerned with the outcome of the current treatment cycle. An example of PAGE 2 for a Screening Mammogram is shown below in figure 21c:



```
                    * * *  EDIT A PROCEDURE  * * *

Patient Name: DEMO,PATIENT (34y/o)                  Chart#: 00-00-54
Case Manager: FUDD,ELMER J.                      Procedure: MAMMOGRAM SCREENING
Cx Tx Need  : Repeat PAP (by JUL 07,1995)             Acc#: MS95-24
PAP Regimen : Pqy (annually) (began OCT 01,1994)
Br Tx Need  : Mammogram, Screening (by MAR 21,1995)
-------------------------------------------------------------------------------
    Breast Symptoms:                          CBE:
    Diagnostic Workup....:    Planned         Date of CBE:
    Followup Dx MAM Views:                    Ultrasound.............:
    Repeat Breast Exam...:                    Biopsy/Lumpectomy.....:
    Other Procedures Performed:               Fine Needle/Cyst Aspir:
    Status of Final Dx:   Workup Complete     Final Diagnosis..:
    Date of Final Dx..:   OCT 1,1995          Stage at Final Dx:
    Status of Tx......:                       Tumor Size.......:
    Date of Tx Status.:                                        (PAGE 2 OF 2)
_______________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^CAPTION' to jump to a field in the current window.

COMMAND:
```

figure 21c

All of the fields in figure 21c contain context-sensitive help, which can be displayed by entering a "?" at the prompt. The following is a brief explanation of each field on the PAGE 2 of the "EDIT A PROCEDURE" screen for Screening Mammograms:

Breast Symptoms..... Answer Yes, No, or Unknown as to whether or not breast symptoms were present when this screening mammogram was performed.

Diagnostic Workup..... Indicate whether further diagnostic workup procedures are planned to follow-up on this procedure. Choose from: 1) Planned, 2) Not Planned, or 3) Undetermined. If the result of the mammogram was normal or WNL, enter 2 ("Not Planned"). If you leave this field blank for a normal mammogram, it will be assumed to be Not Planned on Export.

Followup Dx MAM Views..... Answer "YES" if diagnostic mammograms have been taken as a followup to the abnormal result from this MAM or CBE.

Repeat Breast Exam..... Answer "YES" if a second or repeat breast exam (CBE) was performed as a followup to the abnormal result from this MAM or CBE.

Other Procedures Performed...Enter the names of any other procedures performed that related to this abnormal PAP/MAM/CBE.

Status of Final Dx..... Enter the status of the Final Diagnosis. Choose from: 1) Workup Complete, 2) Workup Pending, 3) Lost to Follow-up, or 4) Workup Refused. If a woman dies before workup has started, enter 3, Lost to Follow-up.

Date of Final Dx..... Enter the date that the Final Diagnosis was made. If the patient was lost to follow-up or refused workup, enter the date of closeout of this procedure.

Status of Treatment..... Enter the current status of treatment for this patient. Choose from: 1) Tx started, 2) Tx pending, 3) Lost to follow-up, 4) Tx refused or 5) Tx not needed. Do not fill this in if the Status of Final Dx is complete. If the woman dies before treatment has begun, enter 3, Lost to follow-up.

Date of Tx Status..... If treatment for cancer has begun, enter the date on which the treatment began. If treatment is pending, leave blank. If this procedure is closed, enter date of closeout.

CBE..... If a CBE was associated with this Screening Mammogram, enter the result. If a CBE was NOT performed, select one of the "Not Done,..." reasons provided.

Date of CBE..... Enter the date of the CBE associated with this Screening Mammogram.

Ultrasound..... Enter "YES" if an ultrasound was performed as a followup to the abnormal result of this procedure.

Biopsy/Lumpectomy..... Enter "YES" if a biopsy or lumpectomy was performed as a followup to the abnormal result from this MAM or CBE.

Fine Needle/Cyst Aspir..... Enter "YES" if a fine needle biopsy or cyst aspiration was performed as a followup to the abnormal result from this MAM or CBE.

Final Diagnosis..... Select the final diagnosis that was made following the workup of this mammogram. Choices are 1) Cancer, in situ; 2) Cancer, invasive; and 3) Cancer not Dx'd.

Stage at Final Dx..... If the Final Diagnosis is "Cancer, invasive", enter the pathologic or clinical stage. If the clinical stage is unknown, enter the summary ("S-") stage.

Tumor size..... If the Final Diagnosis is "Cancer, invasive", select the size range of the tumor (0-<1cm, 1cm to <2cm, 2cm to <5cm, 5cm and greater, unknown).

When you have completed the edits for this PAGE you would save and exit this procedure via the Command Line at the bottom of the screen. When you leave the "EDIT A PROCEDURE" screen, you will always be presented with the Procedure Follow-up Menu (see page 45).

### The Procedure Follow-up Menu

The Procedure Follow-up Menu (shown below in figure 22) does not appear as an option on any menu; however, it always appears after you leave the "EDIT A PROCEDURE" screen. The Procedure Follow-up Menu presents several actions you might take after editing a Procedure. A brief explanation of each option is given below:

```
                        *  PROCEDURE FOLLOW-UP MENU  *

Patient Name: BROWN,SARAH (34y/o)                    Chart#: 00-00-54
Case Manager: FUDD,ELMER J.                        Procedure: PAP SMEAR
Cx Tx Need  : Routine PAP (by JUL 07,1995)             Acc#: PS95-10
PAP Regimen : Pqy (annually) (began OCT 01,1994)
Br Tx Need  : Mammogram, Screening (by MAR 21,1995)
---------------------------------------------- PREGNANT, EDC: 06/04/95 ------

   To take a follow-up action on this procedure, choose:

     A to ADD a NEW Notification for this patient,
     C to review and CLOSE any Open Notifications for this patient,
     E to EDIT this Patient's Case Data,
     P to PRINT all of the information for this Procedure,
     F to display/print this Patient's FACE SHEET,
     Q to QUEUE a "PAP Result Normal" letter to be sent to this patient,
     B to add a Clinical BREAST Exam for this patient,
     or press <return> to continue.

   Select A, C, E, F, P, Q, B, or <return>:
```

figure 22

If you have just entered the result for a Procedure and closed it, *this would be a logical time to...*

A to ADD a NEW Notification.....to add a Results letter to be sent to the patient or to queue a Reminder letter for her next Procedure (same as "Add a NEW Notification" option on page 49).

C to review and CLOSE any Open Notifications.....to review all of the patient's OPEN Notifications. This option will permit you to browse the patient's OPEN Notifications by date, and to close any of them if appropriate, using the "Edit a Notification" screen (see page 52).

E to EDIT Case Data.....to change the patient's Treatment Needs and Needs due dates (same as "Edit Patient Case Data" option).

F to display/print FACE SHEET.....to examine 3rd party payer information.

P to PRINT this Procedure.....to put a paper copy of the Procedure in the patient's chart.

Q to QUEUE a " Result Normal" letter.....This option will appear **only if** the Procedure was a PAP or Mammogram **and** the result was **normal**. This automatically queues a Results letter to be printed as soon as queued letters are printed, and it closes the Notification automatically. (See also Site Parameter setup on page21. These are the “Autoqueue Normal PAP/MAM Letters”.)

B to add a Clinical BREAST Exam.....to add a Clinical Breast Exam if it was done at the same time as this Procedure (usu. a PAP).

### Browse Procedures

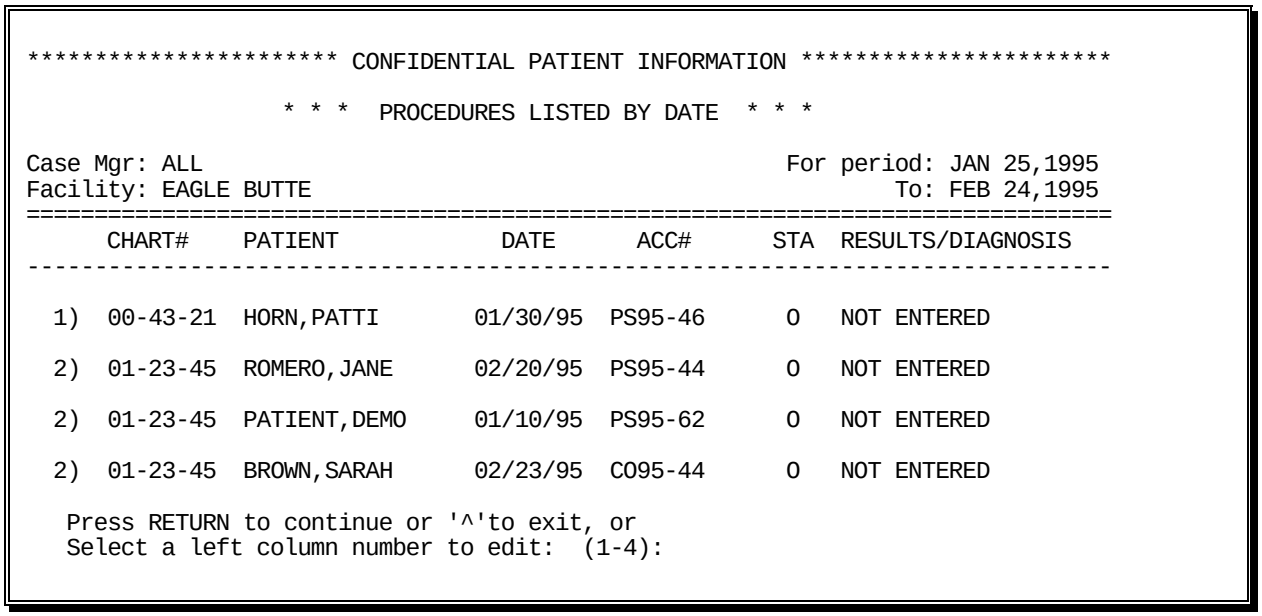
This option allows you to search for and browse through Procedures. The eight questions (see figure 23 below) that are asked prior to the display allow you to specify patients, procedures, date range, Status, Normal/Abnormal, Case Manager (site parameter), order of display, and Device for the printout.

```
             * * *  WOMEN'S HEALTH: BROWSE PROCEDURES  * * *


Browse Procedures for ONE individual patient,
or browse Procedures for ALL Patients?
Select ONE or ALL: ALL//

Include ALL Procedure Types in this listing? Y//

***  Date Range Selection  ***
Begin with DATE:  T-30//  (JAN 25, 1995)
End with DATE:    T//  (FEB 24, 1995)

Do you wish to browse DELINQUENT, NEW, OPEN, or ALL Procedures?
Select DELINQUENT, NEW, OPEN, or ALL: OPEN//

Do you wish to browse only Procedures with ABNORMAL results,
or both ABNORMAL and NORMAL?
Select ABNORMAL or BOTH: ABNORMAL ONLY//

Browse Procedures for ONE particular Case Manager,
or browse Procedures for ALL Case Managers?
Select ONE or ALL: ALL//

Display Procedures in order of:        1) DATE OF PROCEDURE (earliest first)
                                       2) NAME OF PATIENT (alphabetically)
                                       3) PRIORITY (most urgent being highest)
Select 1, 2, or 3: 1//

Select DEVICE: HOME//
```

figure 23

All of the prompts in figure 23 contain context-sensitive help, which can be displayed by entering a “?” at the prompt. For help in answering the “Select DEVICE: ” prompt, please contact your site manager.

An example of the “Browse Procedures” option display is shown below in figure 24. If the Device selected for the Browse Procedures display is “HOME” (to the screen), a column of numbers will appear to the left of the Procedures. If you select one of these numbers at the prompt, you will enter the edit screen for that Procedure.



```
********************** CONFIDENTIAL PATIENT INFORMATION **********************

                   * * *  PROCEDURES LISTED BY DATE  * * *

Case Mgr: ALL                                          For period: JAN 25,1995
Facility: EAGLE BUTTE                                      To: FEB 24,1995
================================================================================
      CHART#    PATIENT            DATE      ACC#      STA  RESULTS/DIAGNOSIS
--------------------------------------------------------------------------------

  1)  00-43-21  HORN,PATTI       01/30/95  PS95-46      O   NOT ENTERED

  2)  01-23-45  ROMERO,JANE      02/20/95  PS95-44      O   NOT ENTERED

  2)  01-23-45  PATIENT,DEMO     01/10/95  PS95-62      O   NOT ENTERED

  2)  01-23-45  BROWN,SARAH      02/23/95  CO95-44      O   NOT ENTERED

   Press RETURN to continue or '^'to exit, or
   Select a left column number to edit:  (1-4):
```

figure 24

**Print a Procedure**

This option allows you to print information pertaining to a patient’s procedure. (Information pertaining to the CDC PAGE 2 is not included in this printout.) You are prompted for an Accession# or Patient Name, and for a Device. For help in answering the “Select DEVICE: ” prompt, please contact your site manager. The display/ printout looks very similar to the “Edit a Procedure” screen (figure 20 on page 38)

**Add an Historical Procedure**

This option allows you to add Procedures for a patient done in years past, in order to make her Patient Profile more complete. Only a minimum of data is required: Date of Procedure, Procedure, Results, HPV status and an optional Health Care Facility. NOTE: This option is locked with the Manager's key and might not appear on all users' menus. An example of adding an historical Procedure is given below in figure 25.

```
              * * *  WOMEN'S HEALTH: ENTER HISTORICAL DATA  * * *


   Select PATIENT:    DEMO,PATIENT           F 12-01-93            EB 999999
   Select PROCEDURE: PAP SMEAR//          PS
   Select DATE:      TODAY// 1-1-92  (JAN 01, 1992)  JAN 01, 1992

RESULTS/DIAGNOSIS: ASCUS
     1   ASCUS          1
     2   ASCUS, malignant          1
     3   ASCUS, premalignant          1
CHOOSE 1-3: 1
HPV: NO
HEALTH CARE FACILITY: EAGLE BUTTE      SOUTH DAKOTA                    ABERDEEN
       CHEYENNE RIV       01
```

figure 25

If you wish to enter more of the data on a Procedure from years past, you may of course add the Procedure through the standard "Add a NEW Procedure" option. There is no requirement to add an old Procedure under the Historical option. It is important, however, that current procedures be added under the "Add a NEW Procedure" option, where many more of the important and relevant fields are available for entering data. This is especially true for CDC-funded sites.

**Add a New Notification**

This option allows you to add Notifications for patients. A Notification is a communication between the clinic staff and the patient. This section will describe Notifications in detail and how to add them for a patient.

When you add a Notification, it must be given a *Type of Notification*. Most Notifications are letters, however, they may also be phone calls, conversations, etc. The table below lists all of the *Types of Notifications* that are available in RPMS Women's Health:

| | |
|---|---|
| CONTACT CHA | MESSAGE VIA PERSON |
| CONTACT PHN | MESSAGE VIA PHONE MACHINE |
| CONVERSATION WITH PATIENT | PHONE CALL, 1ST |
| LETTER, FIRST | PHONE CALL, 2ND |
| LETTER, SECOND | PHONE CALL, 3RD |
| LETTER, SECOND (CERTIFIED) | PROVIDER CONSULT |
| LETTER, THIRD (CERTIFIED) | |

When you add a Notification, it must also be given a *Purpose of Notification*. The *Purpose of Notification* is the reason the patient is being contacted. The table below lists the *Purposes of Notification* that come pre-loaded in RPMS Women's Health. It is possible to add other *Purposes of Notification* customized to your particular site, and to edit the ones listed below as well. (See "Add/Edit a Notification Purpose & Letter" option. page 18)

| | |
|---|---|
| COLP Abnormal, need further TX | PAP result abnormal, PAP 6 weeks P.P. |
| COLP follow up, PAP next month. | PAP result abnormal, next PAP 3 months and colp. |
| COLP follow up, next PAP 6 months. | PAP result abnormal, schedule colposcopy. |
| DNKA Colposcopy (Did Not Keep Appt) | PAP result normal, next PAP 1 year. |
| DNKA Colposcopy Follow Up | PAP result normal, next PAP 4 months. |
| DNKA PAP routine | PAP result normal, next PAP 6 months. |
| DNKA PAP asap | PAP, annual due. |
| DNKA PAP urgent | PAP, follow-up due. |
| MAM result normal, next MAM 1 year. | PREGNANCY Test NEGATIVE |
| PAP abnormal, need colp 8-12 weeks PP. | PREGNANCY Test POSITIVE |
| PAP result abnl, rep PAP 3-6 mos. | |

Eventually, each Notification should be given an *Outcome*. The *Outcome* of a Notification describes the final result of the contact with the patient. The table below lists the *Outcomes* that come pre-loaded in RPMS Women's Health. It is possible to add other *Outcomes* customized to your particular site, and to edit the ones listed below as well. (See "Add/Edit Notification Outcomes" option, page 20.)

| | |
|---|---|
| Chart Flagged | Patient left Service Area |
| Declined Tx | Provider consult |
| MAM Normal letter sent | Response not tracked |
| No known address | Scheduled appt for Colposcopy |
| No response | Scheduled appt for PAP |
| PAP Normal letter sent | Scheduled appt for Repeat PAP |
| PHN referral | Tx elsewhere |
| Patient Deceased | Unable to contact Patient |

As stated above, this option allows you to add Notifications for patients. The first prompt asks you to select a patient (either by name, chart #, or CDC ID#). After you have selected a patient, the "Edit a Notification" screen appears (see figure 26 below). All of the fields in figure 26 contain context-sensitive help, which can be displayed by entering a "?" at the prompt. **NOTE**: For training and assistance in the use of Screens (Screenman) and the Word Processor, please contact your site manager.

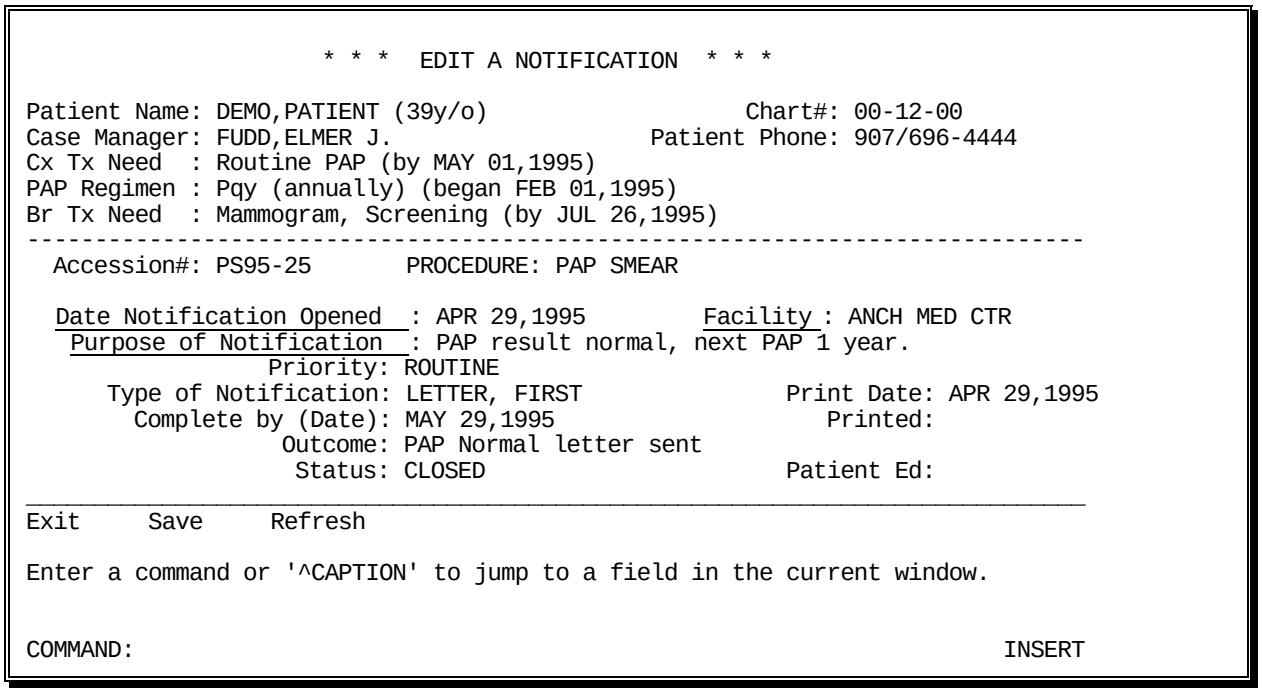



figure 26

The following is a brief explanation of each field in the "EDIT A NOTIFICATION" screen:

Fields above dashed line..... These are the Patient's Case Data fields and are not editable in this screen. They may be edited through the "Edit Patient Case Data" option.

Accession# ..... This Notification may be associated with any pre-existing Procedure for this patient. In the figure 26, for example, the Notification is a Result Letter associated with PAP Procedure PS95-25. This Notification will be displayed as associated with PS95-25 on the Detailed Patient Profile (see the "Patient Profile" option page 33). In other Notifications, this field may be left blank, as in the case of a letter reminding the patient to call for an appointment for an Annual PAP. Only Accession numbers for the patient shown at the top of the screen will be available for selection.

Procedure ..... Filled in automatically, only if an Accession# is chosen.

Date Notification Opened..... (Required) The date the Notification was first created.

Facility ..... (Required) Select the Health Care Facility with which this letter is associated. Each letter to be printed is associated with a specific facility. When a user runs the "Print Queued Letters" option (see page 54), only letters associated with the user's facility will be printed. (The user's facility is the facility (also called "Site" or "Division") that the user selects at sign on. If a user has only one facility, that facility is assigned automatically. For more information about selecting facilities at sign on, contact your site manager.) This feature allows multiple clinics to manage patients and print letters on the same computer, using the same patient database, without printing one another's letters.

Purpose of Notification..... (Required) The reason the patient is being contacted. (See examples, page 49)

Priority ..... Filled in automatically, based on the Purpose of Notification

Type of Notification ..... Letter, phone call, message, etc. (See above, page 49)

Print Date..... Date letter is to be printed. Once the letter has a "Print Date", it will print out on that date (or on any later date) when the option "Print Queued Letters" is run. For example, if the letter is queued to print on Friday but "Print Queued Letters" is not run until the following Monday, then the letter will print out with the Monday batch.

The default date that appears is based on whether the letter is a Results letter or a Reminder letter. If it is a Results letter, the default date is "Today". If it is a Reminder letter, the default date is based on the Due Date of the Treatment Need (Breast or Cervical) to which this Purpose of Notification relates. (See the "Add/Edit a Notification Purpose & Letter" option, page 18.)

Complete by (Date)..... The date after which a Notification will be delinquent or past due if it has not been Closed under the Status field.

Printed ..... Filled in automatically when the letter (if the Notification is a letter) is printed.

Outcome..... Describes the final result of the contact with the patient.

Status ..... Select either OPEN or CLOSED. A Notification is usually left OPEN until an Outcome has been entered. If the Notification is a Results letter, it is usually closed when the letter is printed (no further Outcome is expected). If the Notification is a Reminder letter (reminding the patient to call for a next appointment), it is usually closed either when the patient calls to schedule an appointment, or following the edit of her next Procedure. (See "The Basic Patient Management Loop", page 8). A Notification that is left OPEN past its "Complete by (Date)" will be displayed as "Delinquent" on Notification reports.

Patient Education..... Enter "yes" or "no", depending on whether patient education occurred during the Notification (for phone calls, conversations, etc.). Enter "clinic" or "village" if the patient education occurred at a remote location.

**Note:** If the Notification is a letter and the letter has already been **printed**, most of the fields for that Notification will be **blocked from editing**. This is to keep the data on the computer in sync with the letter that was sent to the patient. Only the bottom four fields (Complete by Date, Outcome, Status, and Patient Ed) will be editable.

After you leave the "EDIT A NOTIFICATION" Screen, if you did not save before exiting you will be asked "Save changes before leaving form (Y/N)?", and if the Notification was a letter, the program will ask, "Do you wish to *preview* or *print* this letter now? Enter Yes or No: NO// " "Preview" allows you to look at the letter that has just been queued. To preview the letter, select HOME at the "DEVICE: " prompt. "Print" will print the letter immediately, regardless of its "Print Date", and remove it from the queue of letters waiting to print. To print the letter immediately, select a printer at the "DEVICE: " prompt. NOTE: For help in answering the "Select DEVICE: " prompt, please contact your site manager.

If you answer "No" to the "Do you wish to *preview* or *print* this letter now?" prompt, the letter will remain in the queue, to be printed on its "Print Date".

In most cases, after the "Edit a Notification" screen the program will ask, "Do you wish to edit this patient's Case Data?". Answer "YES" if you wish to update the patient's Case Data at this point. (See the "Edit Patient Case Data" option, page 31.)

**Edit a Notification**

This option allows you to edit a Notification that already exists. You are first asked to select a patient (by name or chart#), and then a Notification (by date or Accession#). Once you have selected a Notification to edit, the "EDIT A NOTIFICATION" screen will appear (see figure 26 in the previous section).

**Browse Notifications**

This option allows you to search for and browse through Notifications. The six questions (see figure 27 below) that are asked prior to the display allow you to specify patients, date range, Status, Case Manager (site parameter), order of display, and Device for the printout. All of the prompts in figure 27 contain context-sensitive help, which can be displayed by entering a "?" at the prompt. For help in answering the "Select DEVICE: " prompt, please contact your site manager.

```
             * * *  WOMEN'S HEALTH: BROWSE NOTIFICATIONS  * * *

   Browse Notifications for ONE individual patient,
   or browse Notifications for ALL patients?
   Select ONE or ALL: ALL//

   *** Date Range Selection ***
   Begin with DATE: T-30//  (MAR 30, 1995)
   End with DATE:   T//  (APR 29, 1995)

   Do you wish to browse DELINQUENT, OPEN, QUEUED, or ALL Notifications?
   Select DELINQUENT, OPEN, QUEUED or ALL: OPEN// ALL

   Browse Notifications for ONE particular Case Manager,
   or browse Notifications for ALL Case Managers?
   Select ONE or ALL: ALL//

   Display Notifications in order of: 1) DATE OF NOTIFICATION (earliest first)
                                      2) NAME OF PATIENT (alphabetically)
                                      3) PRIORITY (beginning with URGENT)
   Select 1, 2, or 3: 1//   DATE

Select DEVICE: HOME//
```

figure 27

An example of the "Browse Notifications" option display is shown in figure 28 below. If the Device selected for the "Browse Notifications" display is "HOME" (to the screen), a column of numbers will appear to the left of the Notifications. If you select one of these numbers at the prompt, you will enter the edit screen for that Notification. (See the "Edit a Notification" option, page 52.)

```
********************** CONFIDENTIAL PATIENT INFORMATION **********************

                  * * *  NOTIFICATIONS LISTED BY DATE  * * *

Case Mgr: ALL                                          For period: MAR 30,1995
Facility: ANCH MED CTR                                        To: APR 29,1995
================================================================================

      CHART#    PATIENT                   DATE      ACC#       STATUS  PRIORITY
--------------------------------------------------------------------------------

  1)  00-00-54  BROWN,SARAH ...........  04/03/95              OPEN     ROUTINE
  2)  . . . .   . . . . . . . . . . . .  04/12/95              OPEN     ROUTINE
  3)  . . . .   . . . . . . . . . . . .  04/19/95  PS95-8      OPEN
  4)  . . . .   . . . . . . . . . . . .  04/20/95  PS95-8      OPEN
  5)  . . . .   . . . . . . . . . . . .  04/23/95  PS95-12     CLOSED   ROUTINE

  6)  00-12-00  DEMO,PATIENT .........  04/28/95              OPEN
  7)  . . . .   . . . . . . . . . . . .  04/29/95  PS95-25     CLOSED   ROUTINE

   Press RETURN to continue or '^' to exit, or
   Select a left column number to edit:  (1-7):
```

figure 28

**Print Individual Letters**

This option allows you to print individual letters. You are first asked to select a patient (by name or chart#), then a Notification (by date or Accession#), and then a Device to print to. NOTE: For help in answering the “Select DEVICE: ” prompt, please contact your site manager. The letter will print immediately (unless you queue it again), regardless of its "Print Date", and then it will be removed from the queue of letters waiting to print.

**Print Queued Letters**

This option allows you to print all letters that have been queued to print on the current date or on any date prior to the current date. Some of these letters may be Reminder letters, put in the queue weeks or months earlier to print on this date, reminding the patient to call and schedule her next procedure (for example, an annual PAP). Others of these letters may be Results letters queued earlier in the day to print today, informing the patient of results of a recent procedure. Only letters associated with your facility will be printed (see “Facility” page 51).

NOTE: The option to Print Queued Letters checks to see that the patient is not deceased. For a deceased patient, instead of the queued letter printing, an explanation is printed stating that the patient is deceased, that letter will not be printed, and that the notification has been closed and given an Outcome of "Patient Deceased".

## *Management Reports Menu*

### Overview

The Management Reports Menu contains options that provide program management reports and a limited set of epidemiological reports. The Management Reports menu is shown below in figure 29. The remainder of this section will briefly describe each of the options under the Management Reports Menu.

```
     WOMEN'S HEALTH:          *  MANAGEMENT REPORTS  *          EAGLE BUTTE
                              ========================


   PS      Procedure Statistics Report
   SN      Snapshot of the Program Today
   RS      Retrieve/Print Earlier Snapshots
   SR      Screening Rates for PAPs and MAMs
   BP      Browse Patients With Needs Past Due

Select Management Reports Option:
```

figure 29

### Procedure Statistics Report

This option provides a report for each Procedure Type, the numbers of Procedures which have had results of Normal, Abnormal, and No Result. It also provides the numbers of patients who have had Procedures with these results. All results are also expressed as percentages. An example of the report is shown in figure 30 below.

This reports first asks you for a date range, the group of Procedure Types to be included, if you wish to display statistics by age group, and a Device. If you answer Yes to display by age group you will be instructed to enter the age ranges you wish to select for in the form of: 15-29,30-39,40-105. Use a dash "-" to separate the limits of a range, use a comma to separate the different ranges. NOTE: Patient ages will reflect the age they were on the dates of their procedures. (Patient ages will NOT necessarily be their ages today.) All four prompts contain context-sensitive help, which can be displayed by entering a “?” at the prompt. NOTE: For help in answering the “Select DEVICE: ” prompt, please contact your site manager.

```
        * * *  WOMEN'S HEALTH: PROCEDURE STATISTICS REPORT  * * *

Facility: EAGLE BUTTE                                From: 02/26/94 to 02/26/95
================================================================================
     NOTE: Patient numbers are not intended to total.  See documentation.
================================================================================

      ------------------------< COLPOSCOPY 15-20 yrs >------------------------

                        NORMAL:          0  (  0%)
        PROCEDURES      ABNORMAL:        1  (100%)
                        NO RESULT:       0  (  0%)
                        TOTAL:           1

                        NORMAL:          0  (  0%)   Patients may be
        PATIENTS        ABNORMAL:        1  (100%)   included in more
                        NO RESULT:       0  (  0%)   than one category.
                        TOTAL:           1

      ------------------------< PAP SMEAR 15-20 yrs >-------------------------

                        NORMAL:         32  ( 39%)
        PROCEDURES      ABNORMAL:       47  ( 57%)
                        NO RESULT:       4  (  5%)
                        TOTAL:          83

                        NORMAL:         32  ( 42%)   Patients may be
        PATIENTS        ABNORMAL:       45  ( 58%)   included in more
                        NO RESULT:       4  (  5%)   than one category.
                        TOTAL:          77

      -------------------< MAMMOGRAM BILATERAL 15-20 yrs >--------------------

                        NORMAL:          1  (100%)
        PROCEDURES      ABNORMAL:        0  (  0%)
                        NO RESULT:       0  (  0%)
                        TOTAL:           1

                        NORMAL:          1  (100%)   Patients may be
        PATIENTS        ABNORMAL:        0  (  0%)   included in more
                        NO RESULT:       0  (  0%)   than one category.
                        TOTAL:           1
```

figure 30

It is important to note that, in the PATIENTS section for each Procedure Type, the TOTAL may be less than the sum of the three results categories (Normal, Abnormal, and No Result). This is because any individual patient may be included in all three categories of Normal, Abnormal, and No Result. (A patient may have received more than one Procedure during the date range selected, and those Procedures may have had differing results.) Each results category simply gives the number of patients who fell into that category for the date range selected. The TOTAL, however, gives the total number of patients who received that Procedure Type for the date range selected; it counts each patient ***only once***, no matter how many times she may have had the Procedure. For this reason, the TOTAL for the PATIENTS section may be less than the sum of the three results categories.

### Snapshot of the Program Today

This option provides a year-to-date report that gives program statistics at a glance. An example of this report is shown below in figure 31a.
Before displaying the report, the program asks:

```
Should today's Snapshot be stored for later retrieval and comparisons?
Enter Yes or No? NO//
```

If you answer "yes", the results of current date's snapshot will be stored after they have been printed out. These results can then be retrieved in the future (by selecting the date of the desired report) and compared to other Snapshots in order to look at the trends and progress of your program over time. (Note: If a previous snapshot for the current date has been run, it will be overwritten by any later run on the same date.) If you answer "no", the program will simply print the current date's Snapshot without storing it.

The second question asks you to "Select DEVICE: ". Enter HOME to have the report display on the screen. The report is specifically design to fit on one screen. NOTE: For help in answering the "Select DEVICE: " prompt, please contact your site manager.

```
               * * *  PROGRAM SNAPSHOT FOR APR 30,1995  * * *

Facility: RALPH CRAMDEN MEDICAL CENTER
================================================================================

   Total Women in Register: . . . . . .. 2599  100%
   Women Who Are Pregnant: . . . . . .  107    4%
   Women with Cervical Tx Needs not specified or not dated: .. 1337   51%
   Women with Cervical Tx Needs specified and past due: . . ..   76    3%
   Women with Breast Tx Needs not specified or not dated: . .. 2598  100%
   Women with Breast Tx Needs specified and past due: . . . ..    0    0%

   Total Number of Procedures with a Status of "OPEN": . . . .  744
   Number of OPEN Procedures Past Due (or not dated): . . . ..  740
   Total Number of PAP Smears done since Jan 1, 1995: . . . .. 2195
   Total Number of CBEs done since Jan 1, 1995: . . . . . ..    2
   Total Number of Mammograms done since Jan 1, 1995: . . . ..    5

   Total Number of Notifications with a Status of "OPEN": . ..  474
   Number of OPEN Notifications Past Due (or not dated): . . .  122
   Number of Letters Queued (for later printing): . . . . . .. 1054

Press RETURN to continue or '^' to exit:
```

figure 31a

### Retrieve/Print Earlier Snapshots

This option allows you to display or print previous "SNAPSHOT" Reports described in the previous section (see figure 31). At the "Select Snapshot: " prompt, enter the date of the Snapshot you wish to retrieve. Enter "?" and press RETURN, to see a list of previous Snapshots by date.

**Screening Rates for PAPs and MAMs**

This report is designed to serve as an indicator of screening rates for PAPs and MAMs, in other words, it indicates the percentage of women who are returning to the program on a regular basis (e.g., annually) for screenings. The report will display the percentages of women who received PAPs and MAMs for screening purposes only, within the selected date range.

Only patients who have had normal results for procedures in the specified date range are counted; the intent is to exclude any procedures that would involve abnormal results, diagnostic and follow-up procedures, etc. Due to the complexities involved in the treatment of individual cases that involve abnormal results, those patients will not be included, even though some of them may have received screening PAPs or MAMs.

This report, therefore, serves ONLY AS AN INDICATOR (NOT as an exact count of screening rates) for gauging the success rates of annual screening programs. It can be run for several different time frames in order to examine trends. Assuming a screening cycle of one year, a minimum date range spanning 15 months is recommended.

This reports first asks you for a date range, an age group (entered in the form 40-85), if you wish to limit the report to one or more Current Communities, and a DEVICE. All of the prompts contain context-sensitive help, which can be displayed by entering a "?" at the prompt. An example of the report is shown below in figure 31b:

```
          *  WOMEN'S HEALTH: SCREENING RATES FOR PAPS AND MAMS  *

    For Age Range: 40-90                                 For period: 01/01/95
    Communities: ALL                                            To: 04/08/96
================================================================================
    (Note: This report includes all facilities using this database.)

                                SCREENING PAPS
                               ----------------
 # of PAPs:      1      2      3      4      5      6      7      8     9+
 -----------  ------ ------ ------ ------ ------ ------ ------ ------ ------
 # of Women:       6     12      2      0      0      0      0      0      0
 % of Women:     30%    60%   10%     0%     0%     0%     0%     0%     0%


                                SCREENING MAMS
                               ----------------
 # of MAMs:      1      2      3      4      5      6      7      8     9+
 -----------  ------ ------ ------ ------ ------ ------ ------ ------ ------
 # of Women:      10     30      0      0      0      0      0      0      0
 % of Women:     25%    75%     0%     0%     0%     0%     0%     0%     0%

Enter RETURN to continue or '^' to exit:
```

figure 31b

In the example shown in figure 31b above, the report spans a 15 month period for women ages 40 through 90. The report indicates that the largest percentages of women have had two annual screenings (60% for PAPs and 75% for MAMs). The report also indicates that approximately 30% of the women did not return for an annual PAP during this time period, and that approximately 25% did not return for an annual screening mammogram.

This report can be run for a larger time frame, for example, 5 years, in order obtain a broader sampling. If the report were run to cover a 5 year time frame, one would hope to see the highest percentages in the 5 column (assuming the goal is to have women return annually). The report can also be run several times for shorter time periods and the results compared, in order to examine trends.

**Browse Patients With Needs Past Due**

This option is exactly the same as is found under the Patient Management Menu. Please refer to page 35 for a complete description of this option.

## *Manager's Functions Menu*

### Overview

The Manager's Functions Menu (shown below in figure 32) contains options that provide the Program Manager with a set of utilities for configuring the software to the specific needs of the site at which the RPMS Women's Health is being used. It also provides utilities for other program needs, such as customizing letters, managing lab data, making special edits to patient data, exporting data to CDC and managing the PCC Link.

The Manager's Functions menu contains many sensitive options requiring a thorough understanding of the software. For this reason it is locked and will not appear on your menu if you have not been given the appropriate key. If the Manager's Functions Menu does not appear on your Women's Health Main Menu and you believe that it should, contact your site manager. The remainder of this section will briefly describe each of the options under the Manager's Functions Menu.

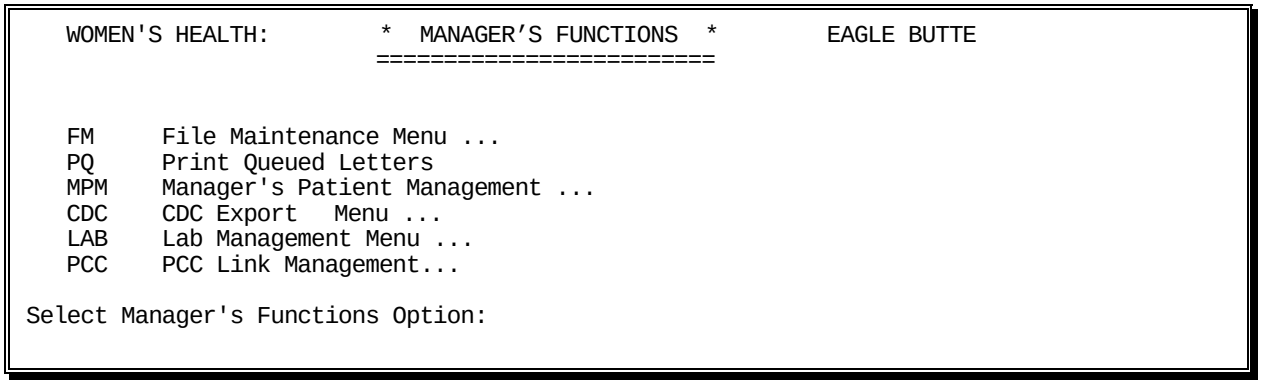



figure 32

### File Maintenance Menu (see Setup, page 17)

The File Maintenance Menu is described in detail under the Setup section, beginning on page 17. Please refer to that section for a complete description of the options under this menu.

### Print Queued Letters

This option is exactly the same as is found under the Patient Management Menu. Please refer to page 54 for a complete description of this option.

**Manager's Patient Management**

This is a menu of options (shown below in figure 33) that allow the Program Manager to view and edit certain types of patient and procedure data in greater detail. Each of the submenu options will be described briefly below.

```
WOMEN'S HEALTH:     *  MANAGER'S PATIENT MANAGEMENT  *     EAGLE BUTTE
                    ================================


PPE     Patient Profile Including Errors
PC      Edit Patient Case Data
HIS     Add an HISTORICAL Procedure
DUP     Browse Procedures for Possible Duplicates
AUTO    Automatically Load Patients
PAL     Edit PAP Regimen Log
PRL     Edit Pregnancy Log
USER    Women's Health Patient Profile
```

figure 33

***Patient Profile Including Errors***

Displays the Patient Profile exactly as described under Patient Profile on page 33, however, it also includes those Procedures given a Results/Diagnosis of “Error/disregard” (See page 39 for “Error/disregard”.) This is the only option in the software that the displays procedures entered in error.

***Edit Patient Case Data***

Allows you to add/edit Patient Case Data. This option is exactly the same as is found under the Patient Management Menu. Please refer to page 31 for a complete description of this option.

***Add an historical Procedure***

Allows entering a minimum of data for procedures done in years past. This option is exactly the same as is found under the Patient Management Menu. Please refer to page 48 for a complete description of this option.

***Browse Procedures for Possible Duplicates***

This utility checks for possible duplicate procedures, in other words, two or more instances of the same procedure for a given patient on the same date. If the selected DEVICE for output is HOME, the program displays the duplicate procedures in a browse/edit mode for convenient cleanup.

***Automatically Load Patients***

This utility examines the main Patient Database for ALL women over a given age and adds them to the Women's Health Database.

You will be asked to select a cutoff age (e.g., 40 and over), and you will be given an opportunity to select for specific Current Communities (based on the RPMS Patient Registration Current Community field). NOTE: Current Community for patients in RPMS Patient Registration must be accurate in order for this utility to be effective. (Sites with Type of Agency set to VA will not be prompted for Current Community.)

Women already in the Women's Health Database will not be added twice. Women who are deceased will not be added. Women added to the Women's Health Database will be given Breast and Cervical Treatment Needs of "Undetermined", with no due dates.

This utility may be run at any time, as often as desired. It may be useful to run it on a monthly basis in order to pick up new women who are added to the RPMS Patient Database.

Before the program begins, you will be prompted for a "DEVICE:". The name, chart#, and date of birth of each patient added to the Women's Health Database will be displayed on the DEVICE. This DEVICE may be a printer, or you may enter "HOME" to have the information simply display on your screen. If the DEVICE you select is a printer, it may be preferable to "queue" the job, in order to free up your terminal. See your computer site manager for assistance with queuing jobs.

WARNING: The first time this utility is run, it may add several thousand patients to the Women's Health Database. It may take several minutes or even hours to run, depending on the size of the database and speed of the computer. Subsequent runs should be much quicker. You may type "^" at anytime to quit before the program begins.

***Edit PAP Regimen Log***

Any changes made to a patient's PAP Regimen on the "Edit Patient Case Data" screen are logged automatically and are displayed on the Patient Profile. If a log entry is in error, it can be edited by the Program Manager using this option.

***Edit Pregnancy Log***

Any changes made to a patient's Pregnancy status on the "Edit Patient Case Data" screen are logged automatically and are displayed on the Patient Profile. If a log entry is in error, it can be edited by the Program Manager using this option.

***Women's Health Patient Profile***

This option is to be placed on other menus outside of the Women's Health package for other users to view a patient's Women's Health profile without edit capability.

The option is placed on this menu so that it can be easily located and reviewed by the Program Manager. When placing this option on another menu, the option name to use is "BW PATIENT PROFILE USER". Contact your site manager for assistance in placing this option on other user's menus outside of the Women's Health package.

The purpose of this option, its use and placement, are more fully described under in the Setup section, *Patient Profile for Other Users/Menus,* on page 27.

**CDC Export Menu**

Several programs in the IHS are participating in the Center for Disease Control (CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which provides funding to programs for the early detection and tracking of breast and cervical cancer. Programs receiving this funding are obligated to submit data, specifically called Minimum Data Elements (MDE's), to CDC on a regular basis. The options on this menu (shown below in figure 34) relate exclusively to the process of submitting MDE's to CDC.
**NOTE: If you are not a CDC funded site, you may ignore this menu.**

```
    WOMEN'S HEALTH:          *  CDC EXPORT MENU  *          EAGLE BUTTE
                            ======================


   NODX   Browse MDE Procedures with No Final DX
   ID     Edit Patient CDC Unique ID Number
   EXP    Export MDE Data for CDC
   PRL    Print CDC Export Log

Select CDC Export Menu Option:
```

figure 34

The following is a brief description of each of the options on this menu.

***Browse MDE Procedures with No Final Dx***

This report examines all procedures marked for export to CDC and determines whether the "Final Diagnosis" field on PAGE 2 of the "Edit a Procedure" screen should be completed. Procedures that require a Final Diagnosis for export and do not have one will appear on the report. If the DEVICE selected for this report is "HOME" (to the screen), a column of numbers will appear to the left of the procedures. If you select one of these numbers at the prompt, you will enter the edit screen for that Procedure. This provides a convenient method of completing all procedure edits prior to export.

***Edit Patient CDC Unique ID Number***

This option allows you to edit the computer-assigned CDC Unique Patient Identification number, should this become necessary.

***Export MDE Data for CDC***

This option is the mechanism by which CDC-funded sites may export the "Minimum Data Elements" to CDC. The program asks a series of questions that help to limit the export to the appropriate patients and procedures. An example of an export is shown below in figure 35.

```
            * * *  WOMEN'S HEALTH: EXPORT MDE DATA FOR CDC  * * *

   Select the Date Range for this export.
     The Begin Date may not precede the Date CDC Funding Began,
     as set on PAGE 2 of the Edit Site Parameters screen.
     The End Date should be the cutoff date for this MDE      Submission.

   *** Date Range Selection ***
   Begin with DATE: JAN 01, 1995
   End with DATE:   DEC 31, 1995

   Include ALL Ward/Clinic/Locations in this listing? Y// ES

   Include ALL Health Care Facilities in this listing? Y// ES

   Include ALL Current Communities in this listing? Y// ES

   Include ALL Providers in this listing? Y// ES

   Do you REALLY wish to export records for CDC now?
   Enter Yes or No? YES// es

   Please hold while records are scanned.  This may take several minutes...

     File /usr2/ihs/pub/SO129523 successfully saved to Host File Server.

     Records exported.....................................:    232
     Total Procedures rejected:  Not done at a selected facility:      0
                                 No facility entered.....:      0

Enter RETURN to continue or '^' to exit:

   The CDC Export Log contains a listing of CDC exports,
   their dates, numbers of records exported, and host filenames.

   Do you with so save this export in the CDC Export Log?
   Enter Yes or No?
```

figure 35

The date range selection is provided so that the appropriate procedures can be exported. Currently (as of April 1996), CDC requests that all procedures from the start date of funding up to the "Cutoff Date" be exported with each submission. This means that each data submission will include *all previous data submitted*, even if many of those procedures have not changed. The date range selection may also be used to work with smaller portions of the data to be exported when making corrections to the RPMS Women's Health database, as described below in the section entitled "Using the MDE Edit Program". Note that the "End with DATE" should be the cutoff date for the data submission, as published in the NBCCEDP DATA USER'S UPDATE newsletter from CDC.

The four questions that follow the Date Range Selection in figure 35 provide an opportunity to set criteria for selecting which procedures will be included in an MDE export. These criteria are: Ward/Clinic/Location, Health Care Facility, Current Community, and Provider. For each criterion the user is given the opportunity to select either all of the entries for that criterion or to limit the export to certain entries. For example, suppose a site uses CDC funding to support only a portion of its program. In order to track and export only those patients who are served by the CDC funding, the site manager might set up specific Ward/Clinic/Locations that are supported by the CDC funding exclusively. The export, then, would be limited to those Ward/Clinic/Locations. (Contact your site manager for help in setting up new Ward/Clinic/ Location entries. These would be added to the Hospital Locations file #44.) In this example, the site manager might set up a "CDC-funded Clinic". Choosing "CDC-funded Clinic" alone during the export would eliminate procedures done in, say, the "General Clinic" or "OB/GYN Clinic". The other criteria (Health Care Facility, Current Community and Provider) can be used in a similar fashion for differentiating and selecting which procedures will be exported.

Once the export has been completed and saved, the a message such as
"File /usr2/ihs/pub/SO129523 successfully saved to Host FileServer." will be displayed.
This is the MDE Data file that should be submitted to CDC. Contact your CDC Program Director and your site manager for help in transporting the file to CDC.

Using the MDE Edit Program

Per current (April 1996) CDC requirements, the export does *not* flag procedures as having been exported; this is because all funded procedures from the date funding began up to the Cutoff Date for the submission are to be included in each export. The export may therefore be run several times, permitting the exported file to be analyzed using the Minimum Data Elements Edit Program provided by Information Management Services, Inc. (IMS). The MDE Edit Program is PC-based software that permits staff at a facility to analyze their data for errors and deficiencies prior to submitting the data to CDC. Once any necessary corrections have been made to the data back in the RPMS Women's Health database, a final export can be run and submitted to CDC.

NOTE: Exported CDC data does not identify patients by name; instead, each patient is assigned a 15-character CDC Unique ID Number (such as, WORBA6008019999). The MDE Edit Program will not provide you with a patient name or chart# when reporting an error; however, will provide the patient's Unique ID Number. When correcting errors reported by the MDE Edit Program in the RPMS Women's Health database, you may enter the Unique ID Number (as reported by the Edit Program) in order to look up the patient. In RPMS Women's Health, at any "Select Patient: " prompt, you may enter the first few characters of the 15-character Unique ID, then select the desired procedure by type and date.

Further details of the IMS program and other aspects of the NBCCEDP are beyond the scope of this manual. Questions in this regard may be addressed to your CDC Program Director.

### *Print CDC Export Log*

At the end of an export, the question is asked, "Do you wish so save this export in the CDC Export Log?" The purpose of the log is to keep a record of the MDE Data submissions to CDC. (In general, one would not save exports run for analysis and data correction using the MDE Edit Program.)

The option "Print CDC Export Log" will give you a report of all past exports saved to the log. An example of this report is shown below in figure 36.

```
BW CDC EXPORT LOG                              JAN  1,1996  13:01    PAGE 1
                TOTAL
DATE           RECORDS       HFS FILENAME
-------------------------------------------------------------------------------

SEP 13,1995        677       /usr2/ihs/pfoster/CR099523
DEC 28,1995        805       /usr2/ihs/pfoster/CR129523


Press RETURN to continue or '^' to exit:
```

figure 36

## Lab Management Menu

This menu has two submenus: Lab Data Entry Menu and Lab Tables/Results Menu.

### *Lab Data Entry Menu*

This menu is provided for sites where Procedures, mainly PAPs, are accessioned in a Lab Department, separate from the department or clinic actually using RPMS Women's Health. This menu has only four options (shown below in figure 37) and may be placed on any menu or secondary menu, totally separate from RPMS Women's Health. To attach this submenu to other menus, contact your site manager. Each of the menu options is described briefly below.

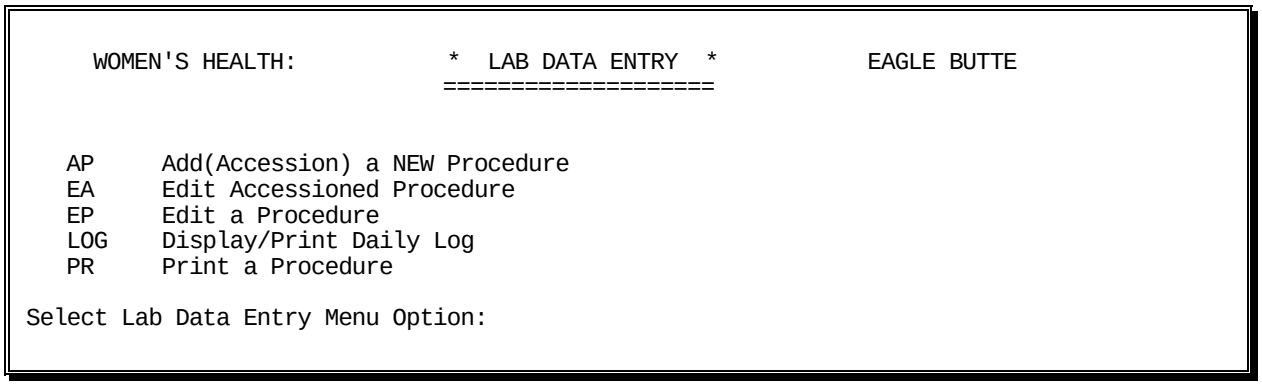



figure 37

Add(Accession) a NEW Procedure

This option allows entering a new Procedure, but only prompts for patient, procedure type, date, provider, clinic and facility. This option is exactly the same as "Add a NEW Procedure" found under the Patient Management Menu, except that the last six fields (Diagnosis, Status, etc.) are not available, since they do not pertain to the lab). Please refer to page 37 for a complete description of this option.

Edit Accessioned Procedure

This option allows editing a Procedure, but only prompts for patient, procedure type, date, provider, clinic and facility. This option allows lab staff to go back and edit or complete data for a procedure they have previously entered. Once again, the last six fields of the Edit a Procedure screen are not available here.

Edit a Procedure

This option allows editing **all** fields of a Procedure. This option is exactly the same as is found under the Patient Management Menu. Please refer to page 38 for a complete description of this option. This option is locked and **not available to the Lab staff unless they have been assigned the appropriate key** (BWZ LAB PCD EDIT). It is placed here so that the Lab Supervisor may enter "Error/disregard" in the Results/Diagnosis field of Procedures that the Lab staff have entered in error. (See page 39 regarding "Error/disregard".)

Display/Print Daily Log

This option allows Lab staff to print a log of all the Procedures that have been added for a selected date range. The six questions (see figure 38 below) that are asked prior to the display allow you to specify the date range, accession area, facility, procedures with no results, procedure totals, order of display, and Device for the printout. All of the prompts in figure 38 contain context-sensitive help, which can be displayed by entering a "?" at the prompt.

```
        * * *  WOMEN'S HEALTH: PRINT LOG OF PROCEDURES ENTRY * * *


*** Date Range Selection ***
Begin with DATE: T-1//  (FEB 26, 1995)
End with DATE:   FEB 26, 1995//  (FEB 26, 1995)

Include ALL Accession Areas in this listing? Y// ES

Select the Facility for the log you wish to display.
Select FACILITY: ANCH MED CTR//

Display ALL Procedures, or only Procedures with NO RESULTS?
Select ALL or NO RESULTS: ALL//

Display data for EACH Procedure, or only just TOTALS?
Select EACH or TOTALS: EACH//

Display Procedures in order of:   1) ACCESSION# (earliest first)
                                  2) PATIENT NAME (alphabetically)
Select 1 or 2: 1//   ACCESSION#

Select DEVICE: HOME//
```

figure 38

An example of the Daily Log is shown below in figure 39.

```
********************** CONFIDENTIAL PATIENT INFORMATION **********************

          * * *  WOMEN'S HEALTH: LAB LOG LISTED BY ACCESSION#  * * *

Facility: EAGLE BUTTE                                From: 02/26/95 to 02/26/95
================================================================================
DATE      ACCESSION#   PATIENT             CHART#    LOCATION    PROVIDER
================================================================================
02/26/95  MB95-3       DEMO,PATIENT        99-99-99  UNKNOWN     UNKNOWN
          Date of MAMMOGRAM BILATERAL: 02/26/95      Entered by: FOSTER,PATRICK
          Results: NOT RECEIVED           Res/Diag: Benign Finding, Negative
--------------------------------------------------------------------------------
02/26/95  PS95-112     DEMO,PATIENT        99-99-99  UNKNOWN     UNKNOWN
          Date of PAP SMEAR: 02/26/95                Entered by: FOSTER,PATRICK
          Results: NOT RECEIVED           Res/Diag: NOT ENTERED
--------------------------------------------------------------------------------
02/26/95  PS95-113     DEMO,PATIENT        99-99-99  UNKNOWN     UNKNOWN
          Date of PAP SMEAR: 02/26/95                Entered by: FOSTER,PATRICK
          Results: NOT RECEIVED           Res/Diag: NOT ENTERED
--------------------------------------------------------------------------------
02/26/95  PS95-114     DEMO,PATIENT        99-99-99  HIGH RISK   UPELL,MARGARET
          Date of PAP SMEAR: 02/26/95                Entered by: FOSTER,PATRICK
          Results: NOT RECEIVED           Res/Diag: Error/disregard
--------------------------------------------------------------------------------
02/26/95  PS95-115     DEMO,PATIENT        99-99-99  UNKNOWN     UNKNOWN
          Date of PAP SMEAR: 02/26/95                Entered by: FOSTER,PATRICK
          Results: NOT RECEIVED           Res/Diag: NOT ENTERED
--------------------------------------------------------------------------------

*     TOTAL PROCEDURES: 5        PROCEDURES WITHOUT RESULTS: 5         *
--------------------------------------------------------------------------------
```

figure 39

Print a Procedure

This option allows printing of Procedures. It is placed here for Lab staff to view all of the information pertaining to individual procedures, for purposes of audits, tracking errors, etc. This option is exactly the same as is found under the Patient Management Menu. Please refer to page 47 for a complete description of this option.

### *Lab Tables/Results Menu*

This menu (shown in figure 40 below) concerns importing lab results (usually Pap smears) from commercial laboratories. At this time the utility is strictly limited to one commercial lab: Corning Clinical Laboratories in El Paso, Texas. As standards for the exchange of patient information, such as HL7, emerge and come into widespread use, it is probable that this RPMS Women's Health utility will be modified to accept data in such formats. The current version, however, is limited to Corning.

```
WOMEN'S HEALTH:          *  LAB TABLES/RESULTS  *          EAGLE BUTTE
                         ========================


   LO      Load Lab Tables/Results
   PN      Print ALL NEW Procedures
   DU      Display Unmatched Lab Results
   PU      Print ALL Unmatched Lab Results
   DEL     Delete Unmatched Lab Result

Select Lab Tables/Results Menu Option
```

figure 40

The import of Corning Lab results proceeds in four stages, which correspond to the options on the above menu:

Stage 1: This involves loading the files received from Corning. This is accomplished using the "Load Lab Tables/Results" option.

Stage 2: The import does **not** change the "Results/Diagnosis:" field of a Procedure; it simply loads the text of the lab result into the "Results Text (WP):" field. (See page38 for a review of the Edit a Procedure screen.) However, all Procedures into which Corning results are import will have their "Status:" field changed to NEW. This is so that those Procedures can be reviewed and the "Results/Diagnosis:" field updated if necessary. Procedures with a Status of NEW can be reviewed either by using the "Browse Procedures" option (see page 46) or by using the "Print ALL NEW Procedures" option on this menu.

Stage 3: Imported lab results are matched with Procedures on the basis of both the Accession# and the Chart# (or SSN for VA sites). If *either* the Accession# or the Chart# does not match, then the imported result is stored as an "Unmatched Lab Result". Using the "Display Unmatched Lab Results" option on this menu it is possible to link up the unmatched lab result with the appropriate Procedure by reviewing name, date, provider, etc.

Stage 4: After an unmatched lab result has been either appropriately linked or deemed unable to be linked to any Procedure, it should be deleted. This can be done either as part of the linking process or by either using the "Delete Unmatched Lab Result" option on this menu.

The following is a brief description of each of the options shown in figure 40.

Load Lab Tables/Results

Lab results from Corning come in two files: an abbreviations table file, and a lab results file. Both files must be loaded with each import. (The records in the results file are actually strings of codes or abbreviations which must be expanded into the full text of the report, using the abbreviations table file.) The import, therefore, is a two-step process: first the Corning Table must be loaded, and then the Corning Results must be loaded.

This option provides the ability to load both the table file and the results file. NOTE: *The table file must be loaded before the results file*. The filenames for each file must be provided by Corning, and the files must already be loaded on the Host File Server in the directory specified on PAGE 2 of the Edit Site Parameters screen (see page 21). Contact your site manager for information and help in loading files.

An example of loading the Corning Abbreviations Table is shown in figure 41 below.

```
        * * *  WOMEN'S HEALTH: UTILITY TO IMPORT LAB RESULTS  * * *


   NOTE: THIS UTILITY IS FOR USE ONLY WITH CORNING CLINICAL LABORATORIES.


   Choose lab name and type of file to upload.
   (Note: The Corning Table must be loaded before the Corning Results.)

     Select one of the following:

          CT        Corning Table
          CR        Corning Results

     Select file name and type: CT  Corning Table

     Enter the name of the file you wish to import.
     Do not include any slashes in the filename.

     Enter filename: ABBTXT1

     Uploading Host File to BW UPLD TABLE TEMP (CORNING) file...
     Indexing BW UPLD TABLE TEMP (CORNING) file.....
     Transferring to "BW UPLD TABLE FINAL (CORNING)" FILE...
     Deleting BW UPLD TABLE TEMP (CORNING) data...
     Complete.


Enter RETURN to continue or '^' to exit:
```

figure 41

The Print ALL NEW Procedures

This option prints all Procedures that have a Status of "NEW". Procedures are automatically given a status of NEW when results from a commercial lab have been imported into them. It is convenient to print or browse (see Browse Procedures page 46) all Procedures with a status of NEW in order to enter or update their Results/Diagnosis fields.

Alternatively, a transcriptionist could manually give Procedures a status of NEW after transcribing lab results into them. This would flag them for review the same as if the results had been imported automatically from a commercial lab.

Display Unmatched Lab Results

This option allows you to select and display any lab results that were imported but could not be matched to any Procedure by Accession# and Chart#. After reviewing the information in an unmatched lab result, you are then given the opportunity to select a Procedure from the Women's Health database to which the unmatched result should be linked. Failure to match is often due to an obvious typographical error in the Accession# or Chart#, and a match on the basis of patient name, date and provider can be made manually, using this option.

Print ALL Unmatched Lab Results

This option allows you to print a paper copy of all unmatched lab results. Some users may find this a more convenient method for working with unmatched lab results.

Delete Unmatched Lab Result

After an unmatched lab result has been either appropriately linked or deemed unlinkable to any Procedure, it should be deleted. This can be done either as part of the linking process or by either using this menu option.

## PCC Link Management

The Women's Health software includes a link that makes it possible to transfer or "pass" data on procedures entered into the Women's Health database over to the RPMS Patient Care Component (PCC). This means that information on PAP Smears and other procedures may appear on the PCC Health Summary, may be available to RPMS Qman searches, and may be picked up by the RPMS Billing software. For information on these other RPMS packages, please refer to the documentation for that software.

The PCC Link Management menu is shown below in figure 42. Options on this menu, in combination with site parameters relating to the individual Procedure Types (see page 24) and in combination with settings made to the PCC MASTER CONTROL file, are used to configure and manage the link between Women's Health and the PCC.

```
   WOMEN'S HEALTH:         *  PCC    LINK MANAGEMENT  *         ANCH MED CTR
                           ========================


   PR      Print PCC Pointers and .01 Values
   ED      Edit PCC .01 Values for Procedures
   CHK     Check PCC Link Status
   DX      Run PCC Link in Diagnostic Mode

Select PCC Link Management Option:
```

figure 42

. Each option is briefly described below:

### *Print PCC Pointers and .01 Values*

Each Procedure Type in Women's Health corresponds to a particular procedure tracked by the PCC. The Women's Health Procedure Types must match the correct procedures known to the PCC by CPT code, Exam code, etc. This display provides information to knowledgeable Medical Records and PCC people regarding exactly which procedures are passed.

### *Edit PCC .01 Values for Procedures*

This option provides the ability to select for each Women's Health Procedure Type the corresponding PCC procedure. While these values come pre-loaded with the Women's Health software, it is possible that certain table files, such as the Radiology Procedures file #71, differ from site to site and that there would be an incorrect matching of procedures. This option, in combination with the option "Print PCC Pointers and .01 Values" described above, provide a mechanism for reviewing and correcting any incorrect matching of procedures between Women's Health and PCC. Further help with this process might be available from Medical Records people or PCC staff at your site.

### *Check PCC Link Status*

This option provides a quick report on the status of PCC and on the status of the Women's Health package in the PCC MASTER CONTROL file. An example report is shown below in figure 43.

```
                WOMEN'S HEALTH-PCC LINK ENVIRONMENT
              ----------------------------------------
     (All parameters must be "YES" for PCC link to be operational.)


   1) PCC is running at this site (RPMS SITE file):.............YES

   2) PCC MASTER CONTROL file is defined for this site:.........YES

   3) VISIT TYPE is defined in the PCC MASTER CONTROL file:.....YES

   4) WOMEN'S HEALTH is defined in the PACKAGE file:............YES

   5) WOMEN'S HEALTH entry exists in the PCC MASTER CONTROL file:..YES

   6) WOMEN'S HEALTH entry in PCC MASTER CONTROL file has
      "PASS DATA TO PCC" set to:................................YES
```

figure 43

As stated in the report, all parameters must return "YES" in order for the link to be operational. These are managed by either your site manager or the PCC manager at your site. In particular, the Women's Health entry in the PCC MASTER CONTROL file must be edited using Fileman. The link is turned off and on by editing the "PASS DATA TO PCC" subfield. (Note: Field 6 will only appear if field 5 is set to YES.)

It is also important to note that this display only concerns the overall operation of the PCC Link. Each Procedure Type must also have its individual PCC parameter set for each facility, as described in the Edit Site Parameters section (see page 24).

***Run PCC Link in Diagnostic Mode***

At the point in the operation of the software where data is passed from the Women's Health package to the PCC, various conditions may cause the link to fail. If this parameter is "YES", an error message will be displayed explaining the nature of the problem. This parameter can also be set on PAGE 2 of the Edit Site Parameters screen (see page 23); it is also placed on this menu for convenience.

# Appendices

## *Appendix A - Results/Diagnosis File by Procedure*

```
          *  WOMEN'S HEALTH: LISTING OF RESULTS/DIAGNOSIS FILE  *
                              * BY PROCEDURE *
-------------------------------------------------------------------------------
  PROCEDURE                       RESULT/DIAGNOSIS           PRIORITY  NORMAL
-------------------------------------------------------------------------------

  BREAST ULTRASOUND               Cystic Mass, Complicated          1  ABNORM
                                  Solid Mass, Irregular Margins     1  ABNORM
                                  Solid Mass, Smooth Margins        1  ABNORM
                                  Cystic Mass                       5  ABNORM
                                  No Discrete Mass                 90  NORMAL

  CLINICAL BREAST EXAM            Bloody Nipple Discharge           1  ABNORM
                                  Discrete Mass                     1  ABNORM
                                  Nipple/Areolar Scaliness          1  ABNORM
                                  Retraction/Dimpling               1  ABNORM
                                  Benign Findings                   6  NORMAL
                                  Not Available                    90  NO RES
                                  WNL/Normal                       90  NORMAL

  COLPOSCOPY IMPRESSION (NO BX)   Impression: Invasive CA           1  ABNORM
                                  Pregnant(no bx),Imp:Invasive      1  ABNORM
                                  Impression: CIN II                2  ABNORM
                                  Impression: CIN III               2  ABNORM
                                  Impression: VAIN II               2  ABNORM
                                  Impression: VAIN III              2  ABNORM
                                  Impression: VIN II                2  ABNORM
                                  Impression: VIN III               2  ABNORM
                                  Pregnant(no bx),Imp:CIN II        2  ABNORM
                                  Pregnant(no bx),Imp:CIN III       2  ABNORM
                                  Impression: CIN I                 3  ABNORM
                                  Impression: HPV                   3  ABNORM
                                  Impression: VAIN I                3  ABNORM
                                  Impression: VIN I                 3  ABNORM
                                  Pregnant(no bx),Imp:CIN I         3  ABNORM
                                  Pregnant(no bx),Imp:HPV           3  ABNORM
                                  Impression: Inflammation          5  ABNORM
                                  Pregnant(no bx),Imp:Inflam        6  NORMAL
                                  Impression: WNL/Normal           90  NORMAL
                                  Not Available                    90  NO RES
                                  Pregnant(no bx),Imp:WNL          90  NORMAL

  COLPOSCOPY W/BIOPSY             Insufficient Tissue               1  NO RES
                                  Invasive CA: Cervical             1  ABNORM
                                  Invasive CA: Other (non-cerv)     1  ABNORM
                                  CIN II/moderate dysplasia         2  ABNORM
                                  CIN III/severe dysplasia          2  ABNORM
                                  Unsatisfactory for Dx             2  NO RES
                                  VAIN II                           2  ABNORM
                                  VAIN III                          2  ABNORM
                                  VIN II                            2  ABNORM
                                  VIN III                           2  ABNORM
                                  CIN I/mild dysplasia              3  ABNORM
                                  HPV/condyloma                     3  ABNORM
                                  VAIN I                            3  ABNORM
                                  VIN I                             3  ABNORM
                                  Inflammation/Cervicitis           5  ABNORM
```

| | | | |
|---|---|---|---|
| COLPOSCOPY W/BIOPSY (cont.) | Benign Changes | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| CONE BIOPSY | Insufficient Tissue | 1 | NO RES |
| | Invasive CA: Cervical | 1 | ABNORM |
| | Invasive CA: Other (non-cerv) | 1 | ABNORM |
| | Other Malignant Neoplasms | 1 | ABNORM |
| | CIN II/moderate dysplasia | 2 | ABNORM |
| | CIN III/severe dysplasia | 2 | ABNORM |
| | Unsatisfactory for Dx | 2 | NO RES |
| | CIN I/mild dysplasia | 3 | ABNORM |
| | HPV/condyloma | 3 | ABNORM |
| | Inflammation/Cervicitis | 5 | ABNORM |
| | Benign Changes | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| CRYOTHERAPY | Done | 92 | NO RES |
| ECTOCERVICAL BIOPSY | Insufficient Tissue | 1 | NO RES |
| | Invasive CA: Cervical | 1 | ABNORM |
| | Invasive CA: Other (non-cerv) | 1 | ABNORM |
| | CIN II/moderate dysplasia | 2 | ABNORM |
| | CIN III/severe dysplasia | 2 | ABNORM |
| | Unsatisfactory for Dx | 2 | NO RES |
| | CIN I/mild dysplasia | 3 | ABNORM |
| | HPV/condyloma | 3 | ABNORM |
| | Inflammation/Cervicitis | 5 | ABNORM |
| | Benign Changes | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| | Not Done | 99 | NO RES |
| ENDOCERVICAL CURRETTAGE | Insufficient Tissue | 1 | NO RES |
| | Invasive CA: Cervical | 1 | ABNORM |
| | Invasive CA: Other (non-cerv) | 1 | ABNORM |
| | CIN II/moderate dysplasia | 2 | ABNORM |
| | CIN III/severe dysplasia | 2 | ABNORM |
| | Unsatisfactory for Dx | 2 | NO RES |
| | CIN I/mild dysplasia | 3 | ABNORM |
| | HPV/condyloma | 3 | ABNORM |
| | Inflammation/Cervicitis | 5 | ABNORM |
| | Benign Changes | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| ENDOMETRIAL BIOPSY | Carcinoma, Non-invasive | 1 | ABNORM |
| | Insufficient Tissue | 1 | NO RES |
| | Invasive CA: Cervical | 1 | ABNORM |
| | Invasive CA: Other (non-cerv) | 1 | ABNORM |
| | Adenomatous Hyperplas w/Atypia | 2 | ABNORM |
| | Adenomatous Hyperplas w/o Atyp | 3 | ABNORM |
| | Endometritis | 5 | ABNORM |
| | Benign Changes | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| FINE NEEDLE ASPIRATION | Carcinoma-in-situ | 1 | ABNORM |
| | Carcinoma-in-situ, NED | 1 | ABNORM |
| | Carcinoma-in-situ, recurrent | 1 | ABNORM |
| | Insufficient Tissue | 1 | NO RES |
| | Invasive Ca | 1 | ABNORM |
| | Invasive Ca, NED | 1 | ABNORM |
| | Invasive Ca, progressive | 1 | ABNORM |
| | Invasive Ca, responding Rx | 1 | ABNORM |
| | Invasive Ca, stable | 1 | ABNORM |

| | | | |
|---|---|---|---|
| FINE NEEDLE ASPIRATION (cont.) | Atypia | 5 | ABNORM |
| | Inflammation | 5 | ABNORM |
| | Benign Findings | 6 | NORMAL |
| GENERAL SURGERY CONSULT | Carcinoma-in-situ | 1 | ABNORM |
| | Carcinoma-in-situ, NED | 1 | ABNORM |
| | Carcinoma-in-situ, recurrent | 1 | ABNORM |
| | Invasive Ca | 1 | ABNORM |
| | Invasive Ca, NED | 1 | ABNORM |
| | Invasive Ca, progressive | 1 | ABNORM |
| | Invasive Ca, responding Rx | 1 | ABNORM |
| | Invasive Ca, stable | 1 | ABNORM |
| | Atypia | 5 | ABNORM |
| | Inflammation | 5 | ABNORM |
| | Benign Findings | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | Error/disregard | 95 | NO RES |
| GYN ONC CONSULT | See Patient Chart/Record | 10 | NO RES |
| | Error/disregard | 95 | NO RES |
| HYSTERECTOMY | Insufficient Tissue | 1 | NO RES |
| | Invasive CA: Cervical | 1 | ABNORM |
| | Other Malignant Neoplasms | 1 | ABNORM |
| | CIN II/moderate dysplasia | 2 | ABNORM |
| | CIN III/severe dysplasia | 2 | ABNORM |
| | Unsatisfactory for Dx | 2 | NO RES |
| | CIN I/mild dysplasia | 3 | ABNORM |
| | HPV/condyloma | 3 | ABNORM |
| | Inflammation/Cervicitis | 5 | ABNORM |
| | Benign Changes | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| LASER ABLATION | Done | 92 | NO RES |
| LASER CONE | Insufficient Tissue | 1 | NO RES |
| | Invasive CA: Cervical | 1 | ABNORM |
| | Other Malignant Neoplasms | 1 | ABNORM |
| | CIN II/moderate dysplasia | 2 | ABNORM |
| | CIN III/severe dysplasia | 2 | ABNORM |
| | Unsatisfactory for Dx | 2 | NO RES |
| | CIN I/mild dysplasia | 3 | ABNORM |
| | HPV/condyloma | 3 | ABNORM |
| | Inflammation/Cervicitis | 5 | ABNORM |
| | Benign Changes | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| LEEP | Insufficient Tissue | 1 | NO RES |
| | Invasive CA: Cervical | 1 | ABNORM |
| | Other Malignant Neoplasms | 1 | ABNORM |
| | CIN II/moderate dysplasia | 2 | ABNORM |
| | CIN III/severe dysplasia | 2 | ABNORM |
| | Unsatisfactory for Dx | 2 | NO RES |
| | CIN I/mild dysplasia | 3 | ABNORM |
| | HPV/condyloma | 3 | ABNORM |
| | Inflammation/Cervicitis | 5 | ABNORM |
| | Benign Changes | 6 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| LUMPECTOMY | Carcinoma-in-situ | 1 | ABNORM |
| | Carcinoma-in-situ, NED | 1 | ABNORM |
| | Carcinoma-in-situ, recurrent | 1 | ABNORM |
| | Insufficient Tissue | 1 | NO RES |
| | Invasive Ca | 1 | ABNORM |

| | | | |
|---|---|---|---|
| LUMPECTOMY (cont.) | Invasive Ca, NED | 1 | ABNORM |
| | Invasive Ca, progressive | 1 | ABNORM |
| | Invasive Ca, responding Rx | 1 | ABNORM |
| | Invasive Ca, stable | 1 | ABNORM |
| | Atypia | 5 | ABNORM |
| | Inflammation | 5 | ABNORM |
| | Benign Findings | 6 | NORMAL |
| MAMMOGRAM DX BILAT | Highly Sug of Malig, Tk Action | 1 | ABNORM |
| | Suspicious Abnorm, Consider Bx | 1 | ABNORM |
| | Assessment Is Incomplete | 2 | NO RES |
| | Unsatisfactory for Dx | 2 | NO RES |
| | Prbly Benign, Short Int F/U | 4 | ABNORM |
| | Benign Finding, Negative | 5 | NORMAL |
| | Indicated, But Not Performed | 5 | NO RES |
| | Not Indicated | 50 | NO RES |
| | Negative | 90 | NORMAL |
| MAMMOGRAM DX UNILAT | Highly Sug of Malig, Tk Action | 1 | ABNORM |
| | Suspicious Abnorm, Consider Bx | 1 | ABNORM |
| | Assessment Is Incomplete | 2 | NO RES |
| | Unsatisfactory for Dx | 2 | NO RES |
| | Prbly Benign, Short Int F/U | 4 | ABNORM |
| | Benign Finding, Negative | 5 | NORMAL |
| | Indicated, But Not Performed | 5 | NO RES |
| | Not Indicated | 50 | NO RES |
| | Negative | 90 | NORMAL |
| MAMMOGRAM SCREENING | Highly Sug of Malig, Tk Action | 1 | ABNORM |
| | Suspicious Abnorm, Consider Bx | 1 | ABNORM |
| | Assessment Is Incomplete | 2 | NO RES |
| | Unsatisfactory for Dx | 2 | NO RES |
| | Prbly Benign, Short Int F/U | 4 | ABNORM |
| | Benign Finding, Negative | 5 | NORMAL |
| | Indicated, But Not Performed | 5 | NO RES |
| | Not Indicated | 50 | NO RES |
| | Negative | 90 | NORMAL |
| MASTECTOMY | Carcinoma-in-situ | 1 | ABNORM |
| | Carcinoma-in-situ, NED | 1 | ABNORM |
| | Carcinoma-in-situ, recurrent | 1 | ABNORM |
| | Insufficient Tissue | 1 | NO RES |
| | Invasive Ca | 1 | ABNORM |
| | Invasive Ca, NED | 1 | ABNORM |
| | Invasive Ca, progressive | 1 | ABNORM |
| | Invasive Ca, responding Rx | 1 | ABNORM |
| | Invasive Ca, stable | 1 | ABNORM |
| | Atypia | 5 | ABNORM |
| | Inflammation | 5 | ABNORM |
| | Benign Findings | 6 | NORMAL |
| NEEDLE BIOPSY | Carcinoma-in-situ | 1 | ABNORM |
| | Carcinoma-in-situ, NED | 1 | ABNORM |
| | Carcinoma-in-situ, recurrent | 1 | ABNORM |
| | Insufficient Tissue | 1 | NO RES |
| | Invasive Ca | 1 | ABNORM |
| | Invasive Ca, NED | 1 | ABNORM |
| | Invasive Ca, progressive | 1 | ABNORM |
| | Invasive Ca, responding Rx | 1 | ABNORM |
| | Invasive Ca, stable | 1 | ABNORM |
| | Atypia | 5 | ABNORM |
| | Inflammation | 5 | ABNORM |
| | Benign Findings | 6 | NORMAL |
| OPEN BIOPSY | Carcinoma-in-situ | 1 | ABNORM |
| | Carcinoma-in-situ, NED | 1 | ABNORM |
| | Carcinoma-in-situ, recurrent | 1 | ABNORM |

| | | | |
|---|---|---|---|
| OPEN BIOPSY (cont.) | Insufficient Tissue | 1 | NO RES |
| | Invasive Ca | 1 | ABNORM |
| | Invasive Ca, NED | 1 | ABNORM |
| | Invasive Ca, progressive | 1 | ABNORM |
| | Invasive Ca, responding Rx | 1 | ABNORM |
| | Invasive Ca, stable | 1 | ABNORM |
| | Atypia | 5 | ABNORM |
| | Inflammation | 5 | ABNORM |
| | Benign Findings | 6 | NORMAL |
| PAP SMEAR | AGCUS | 1 | ABNORM |
| | AGCUS, malignant | 1 | ABNORM |
| | AGCUS, premalignant | 1 | ABNORM |
| | ASCUS | 1 | ABNORM |
| | ASCUS, malignant | 1 | ABNORM |
| | ASCUS, premalignant | 1 | ABNORM |
| | Invasive CA: Cervical | 1 | ABNORM |
| | Other Malignant Neoplasms | 1 | ABNORM |
| | Squamous Cell Carcinoma | 1 | ABNORM |
| | Abnormal Appearing Cervix | 2 | ABNORM |
| | HGSIL: CIS/CINIII/CINII | 2 | ABNORM |
| | Unsatisfactory for Dx | 2 | NO RES |
| | LGSIL: CINI/HPV | 3 | ABNORM |
| | Benign Endometrial Cells | 4 | ABNORM |
| | Benign Cell Chgs: Infection | 5 | ABNORM |
| | Benign Cell Chgs: Other | 5 | NORMAL |
| | Benign Cell Chgs: react/IUD | 5 | NORMAL |
| | Benign Cell Chgs: react/atrphy | 5 | NORMAL |
| | Benign Cell Chgs: react/inflam | 5 | NORMAL |
| | Benign Cell Chgs: react/other | 5 | NORMAL |
| | Benign Cell Chgs: react/radiat | 5 | ABNORM |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| PREGNANCY TEST | Positive | 6 | ABNORM |
| | Negative | 90 | NORMAL |
| STD EVALUATION | 2 or more STD's | 5 | ABNORM |
| | 3 or more STD's | 5 | ABNORM |
| | Chlamydia | 5 | ABNORM |
| | Gonorrhea | 5 | ABNORM |
| | HIV | 5 | ABNORM |
| | Herpes | 5 | ABNORM |
| | Syphilis | 5 | ABNORM |
| | Trichomoniasis | 5 | ABNORM |
| | Positive | 6 | ABNORM |
| | Negative | 90 | NORMAL |
| | Not Available | 90 | NO RES |
| | WNL/Normal | 90 | NORMAL |
| | Error/disregard | 95 | NO RES |
| | Not Done | 99 | NO RES |
| STEREOTACTIC BIOPSY | Carcinoma-in-situ | 1 | ABNORM |
| | Carcinoma-in-situ, NED | 1 | ABNORM |
| | Carcinoma-in-situ, recurrent | 1 | ABNORM |
| | Insufficient Tissue | 1 | NO RES |
| | Invasive Ca | 1 | ABNORM |
| | Invasive Ca, NED | 1 | ABNORM |
| | Invasive Ca, progressive | 1 | ABNORM |
| | Invasive Ca, responding Rx | 1 | ABNORM |
| | Invasive Ca, stable | 1 | ABNORM |
| | Atypia | 5 | ABNORM |
| | Inflammation | 5 | ABNORM |
| | Benign Findings | 6 | NORMAL |
| | Error/disregard | 95 | NO RES |

# *Appendix B - Word Processor Help for Fileman v21*

## WORD PROCESSOR: SCREEN EDITOR HELP

### SUMMARY OF KEY SEQUENCES

**Navigation**

| | |
|---|---|
| Incremental movement | Arrow keys |
| One word left and right | <Ctrl-J> and <Ctrl-L> |
| Next tab stop to the right | <Tab> |
| Jump left and right | <PF1><Left> and <PF1><Right> |
| Beginning and end of line | <PF1><PF1><Left> and <PF1><PF1><Right> |
| Screen up or down | <PF1><Up> and <PF1><Down><br>or: <PrevScr> and <NextScr><br>or: <PageUp> and <PageDown> |
| Top or bottom of document | <PF1>T and <PF1>B |
| Go to a specific location | <PF1>G |

**Exiting/Saving**

| | |
|---|---|
| Exit and save text | <PF1>E |
| Quit without saving | <PF1>Q |
| Exit, save, and switch editors | <PF1>A |
| Save without exiting | <PF1>S |

**Deleting**

| | |
|---|---|
| Character before cursor | <Backspace> |
| Character at cursor | <PF4> or <Remove> or <Delete> |
| From cursor to end of word | <Ctrl-W> |
| From cursor to end of line | <PF1><PF2> |
| Entire line | <PF1>D |

**Settings/Modes**

| | |
|---|---|
| Wrap/nowrap mode toggle | <PF2> |
| Insert/replace mode toggle | <PF3> |
| Set/clear tab stop | <PF1><Tab> |
| Set left margin | <PF1>, |
| Set right margin | <PF1>. |
| Status line toggle | <PF1>? |

**Formatting**

| | |
|---|---|
| Join current line to next line | <PF1>J |
| Reformat paragraph | <PF1>R |

**Finding**

| | |
|---|---|
| Find text | <PF1>F or <Find> |
| Find next occurrence of text | <PF1>N |
| Find/RePlace text | <PF1>P |

## WORD PROCESSOR: SCREEN EDITOR HELP (continued)

**Cutting/Copying/Pasting**

| | |
|---|---|
| Select (Mark) text | <PF1>M at beginning and end of text |
| Unselect (Unmark) text | <PF1><PF1>M |
| Delete selected text | <Delete> or <Backspace> on selected text |
| Cut and save to buffer | <PF1>X on selected text |
| Copy and save to buffer | <PF1>C on selected text |
| Paste from buffer | <PF1>V |
| Move text to another location | <PF1>X at new location |
| Copy text to another location | <PF1>C at new location |

---

## STEPS FOR CHANGING FROM LINE EDITOR TO FULL SCREEN EDITOR IN RPMS MAILMAN

1. **In RPMS**: Select IHS Kernel Option: **MailMan Menu**
2. Select MailMan Menu Option: **OML Other MailMan Functions**
3. Select Other MailMan Functions Option: **EML Edit user options**
4. MESSAGE ACTION DEFAULT: ^ **PREFERRED EDITOR**
5. PREFERRED EDITOR: (Select: **SCREEN EDITOR**)
6. **In Windows**: Switch to Program Manager
7. Go into the Terminal Icon: Settings: Terminal Preferences:
   "Use Function, Arrow, and Ctrl Keys for windows" should not be checked.

## *Appendix C - Common CDC Edit Program Errors*

Compiled by Patrick Foster

This appendix provides helpful information on how to correct MDE data errors as reported by the PC-based MDE Edit Program. For details concerning the MDE Edit Program please refer to page 66.

Listed in this section on each page you will be shown:

1) The MDE Edit Program error as it would appear on the Edit Program error log.
2) An explanation of what caused the error.
3) A corrected PAGE 2 for the error in question.

General Information

If a Screening PAP is coded as a 5 (CINIII/Severe dysplasia/Carcinoma in situ) or as a 6 (Invasive cervical carcinoma), you **must** complete PAGE 2 of the "Edit a Procedure" screen.

If a Mammogram is coded as a 4 (Suspicious abnormality), 5 (Highly suggestive of malignancy), or 6 (Assessment is incomplete), then you **must** complete PAGE 2.

```
**** ID: MOHTA5811171004  ************************************************

   Record ID:  2554 Pap Screening Date:   /  /   Mam Screening Date:  06/27/95
   Record Location:  65
      INTER-FIELD ERRORS:
          38 Dx Workup Breast Should be coded YES
             CBE:  3   MDE   Version:  23
             Scrn Mam Rslts:   6   Dx Wrkup for Breast:  3
          84 Dx Workup Breast Pending, Abn Mam Section Not All Blank
             Dx Wrkup Breast:  3
```

Notes: If the Results/Diagnosis is Assessment Incomplete, then the Diagnostic Workup must be set to Planned. The following fields must be completed: Follow-up Dx MAM Views, Repeat Breast Exam, Ultrasound, biopsy/Lumpectomy, Fine Needle/Cyst Aspir. If these are not completed then you will get one or more of the following errors; 85 through 90. Status of Final Dx can be pending. If workup is complete then the following fields must be completed as well: Final Diagnosis (if this is set to a cancer, then the stage at final Dx and Tumor size must be completed) and Date of Final Diagnosis.

```
_____________________________________________________________________________
Case Manager: KNIFE,MARIETTA                    Procedure: MAMMOGRAM RIGHT
Cx Tx Need  : Undetermined (by JUN 27,1996)          Acc#: MU95-10
PAP Regimen : Undetermined (began )
Br Tx Need  : Mammogram, Screening (by JUN 27,1996)
-----------------------------------------------------------------------------
    Breast Symptoms: NO                  CBE:
    Diagnostic Workup....: Planned       Date of CBE:
    Followup Dx MAM Views: YES           Ultrasound.............: NO
    Repeat Breast Exam...: YES           Biopsy/Lumpectomy.....: YES
    Other Procedures Performed:          Fine Needle/Cyst Aspir: YES
    Status of Final Dx: Workup Complete  Final Diagnosis..: Cancer not Dx'd
    Date of Final Dx..: NOV 6,1995       Stage at Final Dx:
    Status of Tx......:                  Tumor size.......:
    Date of Tx Status.:                            (PAGE 2 OF 2)
```

```
**** ID: 0EELI2207270170  ************************************************

  Record ID:  2578 Pap Screening Date:   /  /   Mam Screening Date:  06/27/95
  Record Location:  82
     INTER-FIELD ERRORS:
         85 Dx Workup Breast YES, FU Dx Mam Views Invalid
            Dx Wrkup Breast:  1   Fup Diag Mam Views:
         86 Dx Workup Breast YES, Repeat Breast Exam Invalid
            Dx Wrkup Breast:  1   Repeat Breast Exam:
         87 Dx Workup Breast YES, Ultrasound Invalid
            Dx Wrkup Breast:  1   Ultrasound:
         88 Dx Workup Breast YES, Biopsy/Lumpectomy Invalid
            Dx Wrkup Breast:  1   Biopsy/Lumpectomy:
         89 Dx Workup Breast YES, Fine Needle/Cyst Aspiration Invalid
            Dx Wrkup Breast:  1   Fine Needle/Cyst:
         90 Dx Workup Breast YES, Other Procedures Performed Invalid
            Dx Wrkup Breast:  1   Other Procs:
         93 Dx Workup Breast YES, Status of Final Dx Should be Completed
            Dx Wrkup Breast:  1   Status Final Dx:
     WARNINGS:
         33 Verify Abn Mam Other Procs Pert and Descr of Other Procs
     Abn Mam Other Procs:      Descr 1:
```

Notes: The most common cause of these errors is that the Results/Diagnosis field on PAGE 1 is not normal and PAGE 2 has not been completed.

```
_____________________________________________________________________________
Case Manager: KNIFE,MARIETTA                    Procedure: MAMMOGRAM SCREENING
Cx Tx Need  : Routine PAP (by OCT 12,1996)           Acc#: MB95-78
PAP Regimen : Pqy (annually) (began OCT 12,1995)
Br Tx Need  : Clinical Breast Exam (by JUN 27,1996)
-----------------------------------------------------------------------------
    Breast Symptoms: NO                  CBE: Normal/Benign Findings
    Diagnostic Workup....: Planned       Date of CBE: OCT 12,1995
    Followup Dx MAM Views: YES           Ultrasound.............: NO
    Repeat Breast Exam...: YES           Biopsy/Lumpectomy.....: NO
    Other Procedures Performed:          Fine Needle/Cyst Aspir: NO
    Status of Final Dx: Workup Complete  Final Diagnosis..: Cancer not Dx'd
    Date of Final Dx..: OCT 12,1995      Stage at Final Dx:
    Status of Tx......:                  Tumor size.......:

    Date of Tx Status.:                            (PAGE 2 OF 2)
```

```
**** ID: MOHTA5811171004  ************************************************

   Record ID:  2554 Pap Screening Date:   /  /   Mam Screening Date:  06/27/95
   Record Location:  65
      ITEM ERRORS:
          19 Invalid Clinical Breast Exam
      WARNINGS:
           6 Verify Relationship Between CBE and MDE     Version
             CBE:         MDE   :
           7 Verify Relationship Between CBE and Date of CBE
             CBE:         CBE Date:    /    /
```

Notes: The most common cause of these errors is that the CBE field and Date of CBE are not complete. If a CBE was not done then the answer should be coded to 4 - Needed but not performed. These two fields must be filled in for every mammogram regardless of the Results/Diagnosis field on PAGE 1.

```
_____________________________________________________________________________
Case Manager: KNIFE,MARIETTA                    Procedure: MAMMOGRAM SCREENING
Cx Tx Need  : Routine PAP (by OCT 12,1996)             Acc#: MB95-78
PAP Regimen : Pqy (annually) (began OCT 12,1995)
Br Tx Need  : Clinical Breast Exam (by JUN 27,1996)
-----------------------------------------------------------------------------
    Breast Symptoms: NO                    CBE: Normal/Benign Findings
    Diagnostic Workup....: Planned         Date of CBE: OCT 12,1995
    Followup Dx MAM Views: YES             Ultrasound.............: NO
    Repeat Breast Exam...: YES             Biopsy/Lumpectomy.....: NO
    Other Procedures Performed:            Fine Needle/Cyst Aspir: NO
    Status of Final Dx: Workup Complete    Final Diagnosis..: Cancer not Dx'd
    Date of Final Dx..: OCT 12,1995        Stage at Final Dx:
    Status of Tx......:                    Tumor size.......:

    Date of Tx Status.:                              (PAGE 2 OF 2)
```

```
**** ID: TERPR5407023520  ************************************************
   Record ID:  15237  Pap Screening Date: 04/10/95 Mam Screening Date:    /  /
   Record Location:  33
      INTER-FIELD ERRORS:
          60 Abn Pap Status of Final Dx Complete, Final Dx Should be Completed
             Dx Wrkup Cerv:  1  Status Final Dx:  1  Final Dx:
          76 Abn Pap Final Dx Indicates Status of Tx Should be Blank
             Status Final Dx:  1  Final Dx:
             Status of Tx: 5  Date of Tx: 10/19/95
```

Notes: The most common cause of this is that the Final Diagnosis has not been completed. Error 76 indicates that you have given a Final Diagnosis and also filled in the Status of treatment. If the Final Diagnosis has been completed, then the Status of treatment should be blank.

```
Case Manager: KNIFE,MARIETTA                      Procedure: PAP SMEAR
Cx Tx Need  : Routine PAP (by OCT 12,1996)             Acc#: PS95-237
PAP Regimen : Pqy (annually) (began APR 10,1995)
Br Tx Need  : Clinical Breast Exam (by OCT 12,1996)
------------------------------------------------------------------------------
    Most recent Colp associated with this PAP:  None
                                  Diagnosis:
    Diagnostic Workup...: Planned
    Other Proc Performed: REPEAT PAP
    Final Dx PAP/Colp...: WNL/Normal
    Status of Final Dx..: Workup Complete
    Date of Final Dx....: OCT 12,1995
    Status of Treatment.:
    Date of Tx Status...:                              (PAGE 2 OF 2)
```

```
**** ID: LBALC4707293851  ************************************************

   Record ID:  1511  Pap Screening Date: 02/02/95  Mam Screening Date:    /  /
   Record Location:  192
      INTER-FIELD ERRORS:
          58 Dx Workup Cerv YES, Status of Final Dx Should be Completed
             Dx Wrkup Cerv:  1  Status Final Dx:
```

Notes: This error is a result of the Results/Diagnosis on PAGE 1 being abnormal and the Diagnostic Workup on PAGE 2 being planned, with the final Dx PAP/Colp being left blank. If the Diagnostic Workup is planned either the Final Dx PAP/Colp or the Status of Treatment should be filled in. The field Other Proc Performed field must also be completed.

```
Case Manager: KNIFE,MARIETTA                      Procedure: PAP SMEAR
Cx Tx Need  : Routine PAP (by JUL 24,1996)             Acc#: PS95-11
PAP Regimen : Pq4mx3, Pq6mx2, Pqy (began JUL 24,1995)
Br Tx Need  : Clinical Breast Exam (by JUL 24,1996)
------------------------------------------------------------------------------
    Most recent Colp associated with this PAP:  None
                                 Diagnosis:
    Diagnostic Workup...: Planned
    Other Proc Performed: COLPOSCOPY
    Final Dx PAP/Colp...: CIN I/mild dysplasia
    Status of Final Dx..: Workup Complete
    Date of Final Dx....: OCT 23,1995
    Status of Treatment.:
    Date of Tx Status...:                              (PAGE 2 OF 2)
______________________________________________________________________________
```

```
**** ID: CALBN5710113137  ************************************************

   Record ID:  15222 Pap Screening Date: 03/20/95  Mam Screening Date:    /  /
   Record Location:  237
      INTER-FIELD ERRORS:
          22 Dx Workup Cerv Should be coded YES
             Scrn Pap Rslts:   5   Dx Wrkup for Cerv:  2
          50 Dx Workup Cerv NO, Abn Pap Section Not All Blank
             Dx Wrkup Cerv:  2
```

Notes: This error is the result of an abnormal Results/Diagnosis on PAGE 1 and a blank PAGE 2. The fields Diagnostic Workup, Other Proc Performed, Final Dx PAP/Colp., Status of Final Dx, and Date of Final Dx, must be completed.

```
Case Manager: KNIFE,MARIETTA                      Procedure: PAP SMEAR
Cx Tx Need  : Routine PAP (by MAR 20,1996)             Acc#: PS95-222
PAP Regimen : Pq6mx2, Pqy (began MAR 20,1995)
Br Tx Need  : Clinical Breast Exam (by MAR 20,1996)
-------------------------------------------------------------------------------
    Most recent Colp associated with this PAP:  None
                                Diagnosis:
    Diagnostic Workup...: Planned
    Other Proc Performed: LEEP
    Final Dx PAP/Colp...: HGSIL: CIS/CINIII/CINII
    Status of Final Dx..: Workup Complete
    Date of Final Dx....: MAR 20,1995
    Status of Treatment.:
    Date of Tx Status...:                              (PAGE 2 OF 2)
_______________________________________________________________________________
```

```
**** ID: TERPR5407023520  ************************************************
   Record ID:  15237  Pap Screening Date: 04/10/95 Mam Screening Date:    /  /
   Record Location:  33
      INTER-FIELD ERRORS:
          60 Abn Pap Status of Final Dx Complete, Final Dx Should be Completed
             Dx Wrkup Cerv:  1  Status Final Dx:  1  Final Dx:
          76 Abn Pap Final Dx Indicates Status of Tx Should be Blank
             Status Final Dx:  1  Final Dx:
             Status of Tx: 5  Date of Tx: 10/19/95
```

Notes: The most common cause of this is that the Final Diagnosis has not been completed. Error 76 indicates that you have given a Final Diagnosis and also filled in the Status of treatment. If the Final Diagnosis has been completed, then the Status of treatment should be blank.

```
Case Manager: KNIFE,MARIETTA                      Procedure: PAP SMEAR
Cx Tx Need  : Routine PAP (by OCT 12,1996)             Acc#: PS95-237
PAP Regimen : Pqy (annually) (began APR 10,1995)
Br Tx Need  : Clinical Breast Exam (by OCT 12,1996)
-------------------------------------------------------------------------------
    Most recent Colp associated with this PAP:  None
                                  Diagnosis:
    Diagnostic Workup...: Planned
    Other Proc Performed: REPEAT PAP
    Final Dx PAP/Colp...: WNL/Normal
    Status of Final Dx..: Workup Complete
    Date of Final Dx....: OCT 12,1995
    Status of Treatment.:
    Date of Tx Status...:                              (PAGE 2 OF 2)
_______________________________________________________________________________
```

```
**** ID: TERPR5407023520  ************************************************
   Record ID:  15237  Pap Screening Date: 04/10/95 Mam Screening Date:    /  /
   Record Location:  33
      INTER-FIELD ERRORS:
          65Abn Pap Date of Final Before Date of Screening Pap
             Dx Wrkup Cerv:  1  Status Final Dx:  1
             Date of Scrn Pap: 12/04/95  Date of Final Dx: 12/03/95
```

Notes: This is caused by the date of the Screening Pap being after the Final Diagnosis. You should make sure that the Date of Final Diagnosis is after the Date of the Screening Pap.

```
Case Manager: KNIFE,MARIETTA                      Procedure: PAP SMEAR
Cx Tx Need  : Routine PAP (by OCT 12,1996)             Acc#: PS95-237
PAP Regimen : Pqy (annually) (began APR 10,1995)
Br Tx Need  : Clinical Breast Exam (by OCT 12,1996)
------------------------------------------------------------------------------
    Most recent Colp associated with this PAP:  None
                                  Diagnosis:
    Diagnostic Workup...: Planned
    Other Proc Performed: REPEAT PAP
    Final Dx PAP/Colp...: WNL/Normal
    Status of Final Dx..: Workup Complete
    Date of Final Dx....: OCT 12,1995   (this must be dated after the Date of the
    Status of Treatment.:                Screening Pap.)
    Date of Tx Status...:                                (PAGE 2 OF 2)
_______________________________________________________________________________
```

```
**** ID: TERPR5407023520  ************************************************
   Record ID:  15237  Pap Screening Date: 04/10/95 Mam Screening Date:    /  /
   Record Location:  33
      ITEM ERRORS:
          11 Invalid State of Residence
             State of Residence:
      INTER-FIELD ERRORS:
           3 Both Resident County and Zip Code Blank
             County of Residence:        Zip Code of Residence:
```

Notes: The most common cause of this is that the State, County and Zip Code of Residence is blank in the Patient Registration package. If you do not have access to the Patient Registration package, you will need to contact the department at your facility that is responsible for that package and have them update the information.

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